DEATH BY DEFAULT

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I
INTRODUCTION

Every day, people are helped or allowed to die. Respirators are disconnected, life-saving operations are not performed, and doctors and nurses stand by doing nothing as patients in distress die under Do-Not-Resuscitate ("DNR") orders. These practices are routine in modern hospitals. Indeed, one study of all cardiopulmonary arrests that occurred while in the hospital found that 75% of the patients were allowed to die because they were under a DNR order.[1] Another study found that 39% of all deaths in intensive care units were preceded by DNR orders.[2] Today you almost need someone else's permission to die.

Polls show that most Americans would not want to be kept alive if there were no hope of recovery.[3] To meet the public's desire for an earlier death, states have rushed to enact right-to-die statutes and to put living wills, medical durable powers of attorney, and advance directives on a stronger legal footing.[4] Although living wills and powers of attorney could theoretically be used to insist that all heroic efforts be made to preserve life, the assumption of the legislators who propose them, the hospitals that market them, and the patients who execute

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1. Susanna E. Bedell et al., *Do-Not-Resuscitate Orders for Critically Ill Patients in the Hospital: How Are They Used and What Is Their Impact?*, 256 JAMA 233 (1986).

2. Jack E. Zimmerman et al., *The Use and Implications of Do Not Resuscitate Orders in Intensive Care Units*, 255 JAMA 351 (1986). For a discussion of the use of DNR orders, see Robert I. Misbin, *Do-Not-Resuscitate Orders*, 77 J. FLA. MED. ASS'N 901 (1990); C.J. Stolman et al., *Evaluation of Patient, Physician, Nurse, and Family Attitudes Toward Do Not Resuscitate Orders*, 150 N.J. ARCHIVES INTERNAL MED. 653 (1990); Robert M. Veatch, *Deciding Against Resuscitation: Encouraging Signs and Potential Dangers*, 253 JAMA 77 (1985); Stuart J. Youngner et al., *"Do Not Resuscitate" Orders: Incidence and Implications in a Medical Intensive Care Unit*, 253 JAMA 54 (1985); Steven H. Miles & Timothy J. Crimmins, *Orders to Limit Emergency Treatment for an Ambulance Service in a Large Metropolitan Area*, 254 JAMA 525 (1985); Anthony Miller & Bernard Lo, *How Do Doctors Discuss Do-Not-Resuscitate Orders?*, 143 W. J. MED. 256 (1985).

3. *See* Appendix Tables 1-8.

4. *See infra* part IV. B.

them is that they will facilitate death—an early death rather than the degraded life that the state or a hospital might impose on them.

Even the right-to-die statutes typically operate only when the patient or someone acting for the patient has spoken. Somewhat reluctantly and with much handwringing, most courts have been willing to enforce the wishes of terminally ill patients, as long as those wishes are sufficiently clearly expressed. But if they are not clearly expressed, some courts, especially recently,[5] have mandated that the patients be kept alive. In other words, the default rule applied by many courts and medical ethicists is life aggressively pursued by medical treatment, even if ultimately treatment is usually withdrawn.

Yet if most people would not want to be kept alive with high technology, why do we require proof that they want what most people want? Why not require proof that they're different than most people, that they would want to be kept alive on life-support? If the patient's wishes are unknown, follow the course that most people would want for themselves in desperate end-of-life situations—a withdrawal of treatment to allow an earlier death.

In this Article, I examine the default rule of life under the usual standards and justifications for default rules in law and economics. I argue that the default rule in end-of-life situations should be death rather than life. Usually, a default rule is the rule the party would have chosen if she could speak. Here it usually isn't. Or it promotes efficiency in the form of wealth maximization. Here, it doesn't. Or it promotes efficiency in the form of happiness, welfare, or general utility. If people are the best judges of their own happiness or utility, once again, it doesn't. Under these standards, life as the default rule in end-of-life situations is unjustifiable. Last, I briefly analyze the more ambiguous preference for family decisionmaking.

II
LIFE BY DEFAULT

A. Medical Default Rule

The default rule as presented by most medical ethicists is life. As Ezekiel Emanuael explains:

> [F]rom medical school on, from their mentors' and their patients' expectations, their instincts are well trained to intervene to prolong life. Indeed, physicians are rarely challenged for intervening but often criticized for "going slow." "Physicians do not easily accept the conception that it may be best to do less, not more, for a patient.

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5. *See* Cruzan v. Missouri Dept. of Health, 497 U.S. 261 (1990); *In re* Westchester County Medical Center on behalf of O'Connor, 531 N.E.2d 607 (N.Y.2d 1988); Bernard Lo & Robert Steinbrook, *Beyond the* Cruzan *Case: The U.S. Supreme Court and Medical Practice,* 114 ANNALS INTERNAL MED. 895 (1991) ("The decision [in *Cruzan*] also has potentially harmful consequences. It may undermine family decision making, encourage cynicism and disregard of the law, and promote defensive medicine."); *see also* discussion at text accompanying notes 34-62.

> The decision to pull back is much more difficult to make than the decision to push ahead with aggressive support." Whether it is positively affirmed, liberally espoused, or instinctively assumed, *prolonging life becomes the "default" response* for physicians facing clinical decisions without clear guidelines on terminating care. As a result, aggressive treatment, without concern for the "whole" patient—the physicalization of medicine—is the standard of care.[6]

Note that Emanuel even conceptualizes the rule as a "default" response. In one standard medical ethics textbook, *Medical Ethics*, Jack Siebe also expresses the rule in terms of default:

> DEFAULT MODE
> If there is no choice of care statement or the patient is not competent, the physician's safest course of action is to assume that the patient wants all available treatments to preserve life, unless it can be documented otherwise.[7]

In *Ethics at the Edges of Life*, Paul Ramsey argues for a doctor's "undiminished obligation first of all to sustain life."[8] Ramsey believes that doctors should ask only which treatments are medically beneficial, not "whether patients' lives are beneficial to them."[9]

In one medical ethics text, a chapter authored by two medical school professors and a social worker concludes that feeding and hydration are mandatory where the patient's life would be prolonged and the patient hasn't expressed contrary wishes:

> Therefore, in applying these two forms of therapy [hydration and feeding], two critical questions to ask in the decision-making process are these: (1) Will therapy effectively palliate the patient? (2) *Will survival be prolonged?* If the answer to *either* of these questions is in the affirmative and the patient has not expressed wishes to the contrary at some other time, then these therapies are mandatory.[10]

The odd logic of their approach can be seen in the following passage, expanding their view:

> Intravenous fluids and alimentation prolong survival. There is no reason from a medical point of view *not* to provide this therapy. Failure to recommend or institute this therapy in the patient who has not expressed wishes to the contrary is a quality of life decision.

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6. EZEKIEL J. EMANUEL, THE ENDS OF HUMAN LIFE 91 (1991) (emphasis added) (citations omitted).

7. Jack C. Siebe, *The Patient's Choice of Care: Suggested Hospital Policies, in* MEDICAL ETHICS 418 (John F. Monagle & David C. Thomasma eds., 1988).

8. PAUL RAMSEY, ETHICS AT THE EDGES OF LIFE 165 (1978) (referring to "prognosis of fatal illness, severe uncorrectable defect, incurability, or nonrecovery" in unconscious patients not yet "dying").

9. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 157 (3rd ed. 1989) (discussing Ramsey).

10. Kenneth C. Micetich et al., *Intravenous Fluid and Nutritional Therapies and the Chronically Ill Patient, in* MEDICAL ETHICS, *supra* note 7, at 180.

> Quality-of-life modifications of the medical recommendation are proper when it is the patient who is making them. Those who provide care for these patients should speak with them frequently and work with them so that when a critical event occurs, a plan which is based on patient wishes and preferences has already been made. The concept of a living will helps remind all of us to do this. *But in the absence of such prior directives, the patient must be treated.* Thus, these patients should be nutritionally supported and hydrated. When these patients develop acute, reversible medical or surgical illnesses, in the absence of patient wishes to the contrary, there is no medical reason not to treat.[11]

Although these health-care professionals are obviously earnest, decent people, I find their paternalism chilling. They conflate prolonging life with maximizing patient welfare. They suggest treating patients when they wouldn't want to be treated. Indeed, on the same page they admit:

> [F]rom our own life experiences and from talking to our patients and their families, we know that most people would not want to be bedridden, be force-fed artificially, or be unable to care for themselves. Yet, we feel uncomfortable making a quality of life decision for others. It is proper that the medical profession should refrain from making these types of decisions.[12]

They fall back on their own default rule—medical care when it prolongs life—unless patients have left living wills or other advance directives. Yet quality-of-life decisions are unavoidable in any event. Someone must decide either that life is worth living or that it isn't. Their approach not only makes a quality-of-life decision for patients—even a desperate life is of good enough quality to be kept alive—but it also makes a quality-of-life decision that neither patients nor families would want.

B. Legal Default Rules

End-of-life decisions may be every-day decisions, but they're not routine when the law gets involved.[13] There are almost as many appellate approaches to withdrawing life-sustaining treatment as there are appellate cases.[14] But some generalizations are possible. When people are competent, their treatment decisions are almost always followed.[15] This reflects the philosophical principle

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11. *Id.* at 181-82 (emphasis added).
12. *Id.* at 182.
13. One study found that in pediatric treatment withdrawals, the hospital's bioethics committee seldom got involved. Larry S. Jefferson et al., *Use of the Natural Death Act in Pediatric Patients*, 19 CRITICAL CARE MED. 901 (1991).
14. Indeed, the *Conroy* court uses three tests: a subjective test, a limited-objective test, and a pure-objective test. *In re* Conroy, 486 A.2d 1209 (N.J. 1985).
15. United States v. George, 239 F. Supp. 752 (D. Conn. 1965). One exception is when children are involved and a good outcome will probably result from treatment: then courts frequently override parents who want to withhold treatment or to try quack remedies. *See, e.g.*, Newmark v. Williams, 588 A.2d 1108 (Del. 1991) (lower court awarded custody of child to state to authorize the hospital to treat the child).

of autonomy, the old common law doctrine of consent, the newer doctrine of informed consent, individual liberty, and the constitutional right of privacy.[16]

When patients, however, are incompetent, demented, partially conscious, or unconscious, they must rely on others to follow their wishes. When those wishes were expressed clearly in a written directive, such as a living will, again they are usually followed. When those wishes were expressed ambiguously, or no wishes were expressed, or the patient was never competent, then the wishes of others become more important, sometimes paramount. Two standards are most often used—the *substituted judgment* standard and the *best interests* standard.

Under the substituted judgment approach, decisions are made by a family member, guardian, agent, or proxy designated in a durable power of attorney or other directive.[17] The proxy stands in the shoes of the patient and is supposed to reflect what the patient would have wanted.[18] But in practice this approach sometimes merges into the other main approach, the best interests standard.[19] As the Delaware Supreme Court put it confusingly, "This Court must therefore substitute its own objective judgment to determine what is in [the patient's] 'best interests.'"[20] Robert Veatch argues similarly, "In the limiting case where we know nothing about the patient's [idiosyncratic] wishes, what could substituted judgment mean other than doing what is most objectively determined to be in the patient's interests?"[21]

Under the best interests standard, the condition of the patient and the probable effectiveness of treatment are most important (though these are certainly the chief factors considered by the patient or her proxy under other approaches).[22] Sometimes treatments that merely prolong life are treated as beneficial;[23] sometimes they aren't.[24] There is some empirical evidence that

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16. Cruzan v. Missouri Dep't of Health, 497 U.S. 261 (1990); *In re* Quinlan, 355 A.2d 647 (N.J. 1976); Bouvia v. Superior Court, 179 Cal. App. 3d 1127 (1986); *see* Kristine C. Karnezis, Annotation, *Patient's Right to Refuse Treatment Allegedly Necessary to Sustain Life,* 93 A.L.R.3D 67 (1979); GERALD DWORKIN, AUTONOMY (1989).

17. *See, e.g.,* Foody v. Manchester Memorial Hospital, 482 A.2d 713 (Conn. Super. Ct. 1984); *In re* L.H.R., 321 S.E.2d 716 (Ga. 1984).

18. *See* Barber v. Superior Court, 147 Cal. App. 3d 1006, 1021 (1983) (surrogate should be guided by previously expressed desires of the patient); *In re* Severns, 425 A.2d 156 (Del. Ch. 1980) (prospective guardian's request granted to withdraw respirator and feeding tube honored because of patient's previously expressed wishes); Kennedy Hospital v. Bludworth, 452 So. 2d 921 (Fla. 1984) (under substituted judgment rule, living will should usually be given effect).

19. Robert M. Veatch, *An Ethical Framework for Terminal Care Decisions: A New Classification of Patients,* 32 J. AM. GERIATRICS SOC'Y 665, 667 (1984).

20. Newmark v. Williams, 588 A.2d 1108, 1117 (Del. 1991).

21. Veatch, *supra* note 19, at 667.

22. An ALR annotation summarizes the outcomes of many end-of-life cases:

> [A] reading of the cases collected here suggests that a diagnosis that the patient is comatose, semicomatose, or in a chronic vegetative state in conjunction with a prognosis of no reasonable probability that the patient will attain cognitive functioning is likely to be regarded by the courts as a sufficiently severe medical condition to order discontinuance of life-sustaining treatment.

John D. Hodson, Annotation, *Judicial Power to Order Discontinuance of Life-Sustaining Treatment,* 48 A.L.R. 4TH 67, 76 (1986).

23. *In re* Christine Busalacchi, 1991 Mo. App. LEXIS 315 (1991) (state argued that treatment was beneficial).

relatives who try to guess what patients would choose for themselves do a better job matching patient choices than relatives told to make their best recommendation.[25] This result supports a version of the substituted judgment approach that actually tries to choose as patients would. Other approaches suggested by commentators include following the wishes of the family.[26]

Theoretically, there are legal constraints on doctors who treat without consent. Unconsented treatment is a battery and can give rise to a civil action for damages.[27] In fact, however, someone brought to an emergency room unconscious from the scene of an automobile accident will usually be treated without consent.[28] The law reasonably assumes that most people would consent to treatment in an emergency.[29] If informed consent[30] is impossible, doctors should get ordinary consent; that served the common law for centuries. If neither informed consent nor simple consent is possible, then implied consent must be used.[31] Where even implied consent is lacking—that is, the patient probably wouldn't consent if she were competent—in my opinion the doctor has no right to treat. As the Massachusetts Supreme Court has argued, "The fact that a person is incompetent should not result in the denial of that person's right to be free from nonconsensual invasions of bodily integrity."[32] Inexplicably, however, if the patient's right to refuse treatment is not expressed clearly, most doctors and courts seem to think that doctors should have a right to treat even where consent can't reasonably be implied.

The legal constraints often dissolve in practice. As the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research explains:

> A number of constraints on the range of acceptable decisions about life-sustaining treatment have been suggested. They are often presented in the form of dichotomies:

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24. *See* Cruzan v. Missouri Dep't of Health, 497 U.S. 261, 310 (1990) (Brennan, J., dissenting); THE PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FORGO LIFE-SUSTAINING TREATMENT 89 (1983).

25. Tom Tomlinson et al., *An Empirical Study of Proxy Consent for Elderly Persons,* 30 GERONTOLOGIST 54, 60 (1990).

26. *See* Nancy K. Rhoden, *Litigating Life and Death,* 102 Harv. L. Rev. 375, 437-45 (1988); M.R. Bliss, *Resources, the Family and Voluntary Euthanasia,* 40 BRIT. J. GEN. PRACTICE 117 (1990).

27. Leach v. Shapiro, 469 N.E.2d 1047 (Ohio Ct. App. 1984); Banks v. Wittenberg, 266 N.W.2d 788, 791 (Mich. Ct. App. 1978); Young v. Oakland General Hospital, 437 N.W.2d 321 (Mich. Ct. App. 1989); SOCIETY FOR THE RIGHT TO DIE, THE PHYSICIAN AND THE HOPELESSLY ILL PATIENT 23, 69 (1985).

28. Delahunt v. Finton, 221 N.W. 168 (Mich. 1928).

29. *Id.*

30. *See* Jeffrey S. Janofsky, *Assessing Competency in the Elderly,* 45 GERIATRICS 45 (Oct. 1990) ("The doctrine of informed consent requires that a patient understand the medical procedure being proposed, that consent be voluntary, and that the patient be competent to give consent."). *See also* Tom L. Beauchamp & James F. Childress, *Informed Consent, in* MEDICAL ETHICS 3-11 (Natalie Abrams & Michael D. Buckner eds., 1983); Alexander M. Capron, *Informed Consent in Catastrophic Disease Research and Treatment,* 123 U. PENN. L. REV. 340, 364 (1975); Note, *Informed Consent and the Dying Patient,* 83 YALE L.J. 1632, 1636-38 (1974).

31. *See* Banks v. Wittenberg, 266 N.W.2d 788 (Mich. Ct. App. 1978); Delahunt v. Finton, 221 N.W. 168 (Mich. 1928); Young v. Oakland General Hospital, 437 N.W.2d 321 (Mich. Ct. App. 1989).

32. Guardianship of Doe, 583 N.E.2d 1263, 1267 (Mass. 1992); *see also* Matter of Moe, 432 N.E.2d 712, 718 (Mass. 1982).

> an omission of treatment that causes death is acceptable whereas an action that causes death is not; withholding treatment is acceptable whereas withdrawing existing treatment is not; extraordinary treatment may be foregone but ordinary treatment may not; a person is permitted to do something knowing that it will cause death but may not aim to kill. The Commission has concluded that none of these dichotomies should be used to prohibit choosing a course of conduct that falls within the societally defined scope of ethical medical practice. Instead, the Commission has found that a decision to forego treatment is ethically acceptable when it has been made by suitably qualified decisionmakers who have found the risk of death to be justified in light of all the circumstances. Furthermore, the Commission has found that nothing in current law precludes ethically sound decisionmaking.[33]

Before the *O'Connor*[34] and *Cruzan*[35] cases of the last few years, in almost all cases where the patient's current condition and medical prognosis were very poor, the treatment was allowed to be withdrawn.[36] As the Missouri Supreme Court stated in *Cruzan*, "Nearly unanimously, these courts have found a way to allow persons wishing to die, or those who seek the death of a ward, to meet the end sought."[37] On the other hand, many cases where the current condition and medical prognosis were very good mandated treatment or chose the course likely to lead to treatment.[38] *O'Connor* and *Cruzan*[39] raised a high evidentiary standard, consolidating and expanding a line of earlier cases that included *Storar*[40] and *Conroy*.[41]

These four cases used the standard requirement that the patient's wish to withdraw treatment must be "clear and convincing" to be given effect. Other cases using this high evidentiary standard include *Jobes*,[42] *Gardner*,[43] *Longeway*,[44] *Barry*,[45] *McConnell*,[46] and *Leach*.[47] Yet why require that the

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33. THE PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 89 (1983). *See* Alan Meisel, *Legal Myths About Terminating Life Support,* 151 ARCHIVES INTERNAL MED. 1497 (1991):

> These [myths] . . . are (1) anything that is not specifically permitted by law is prohibited; (2) termination of life support is murder or suicide; (3) a patient must be terminally ill for life support to be stopped; (4) it is permissible to terminate extraordinary treatments, but not ordinary ones; (5) it is permissible to withhold treatment, but once started, it must be continued; (6) stopping tube feeding is legally different from stopping other treatments; (7) termination of life support requires going to court; and (8) living wills are not legal.

34. *In re* Westchester County Medical Center on behalf of O'Connor, 531 N.E.2d 607 (N.Y. 1988).
35. Cruzan v. Missouri Dep't of Health, 497 U.S. 261 (1990).
36. Cruzan v. Harmon, 760 S.W.2d 408, 413 (Mo. 1988).
37. *Id.*
38. *See* Karnezis, *supra* note 16, at 80.
39. Lo & Steinbrook, *supra* note 5, at 895 ("The decision [in *Cruzan*] also has potentially harmful consequences. It may undermine family decision making, encourage cynicism and disregard of the law, and promote defensive medicine.").
40. *In re* Storar, 420 N.E.2d 64 (N.Y. 1981).
41. *In re* Conroy, 486 A.2d 1209 (N.J. 1985).
42. *In re* Jobes, 529 A.2d 434, 443 (N.J. 1987).
43. *In re* Gardner, 534 A.2d 947, 953 (Me. 1987).
44. *In re* Estate of Longeway, 549 N.E.2d 292 (Ill. 1989).
45. *In re* Guardianship of Barry, 445 So. 2d 365, 372 (Fla. Dist. Ct. 1984).
46. McConnell v. Beverly Enterprises-Connecticut, 553 A.2d 596, 604 (Conn. 1989).
47. Leach v. Akron General Medical Center, 426 N.E.2d 809, 815 (Ohio Ct. App. 1980).

wishes be clear before a patient may be allowed to end treatment? Why not require clear proof that the patient would want to continue treatment—for it's the desire to continue treatment that's unusual?

In *Storar*[48] the patient was seriously retarded. Because his wishes were unknown and unknowable, treatment was continued.[49] The court believed that it would be improper for the court to substitute its own judgment for the unascertainable wishes of the patient. Yet, of course, the court did substitute its judgment.

In *Conroy*[50] the wishes of the patient, her family, and her guardian to avoid life-sustaining treatment were ignored because the patient's wishes were not "clear and convincing." The patient was dying and was unable to move from a semi-fetal position. Her leg was gangrenous up to the knee. She was "severely demented" but interacted with her environment to a slight extent. For example, she sometimes moaned when fed through her tube or when her bandages were changed. Her nephew and guardian said that all his aunt "wanted was to . . . have [her] bills paid and die in [her] own house."[51] The patient feared and avoided doctors and never was seen by one until she became incompetent. The New Jersey Supreme Court held that hydration and feeding could not be withdrawn (though the patient died during the litigation). And it set out an elaborate procedure to be followed before treatment could be withdrawn in other cases.[52]

In *O'Connor* the New York Court of Appeals upheld an order to insert a nasogastric feeding tube into a 77-year-old woman rendered incompetent by strokes. The patient's daughters, who were both practical nurses, opposed the hospital's attempt to have the tube inserted. According to testimony by various witnesses about conversations with the patient over many years, the patient had stated that:

(1) she would not want to be a burden;
(2) she would not want to lose her dignity before she passed away;
(3) "nature should take its course";
(4) "artificial means" should not be used to prolong life;
(5) it is "monstrous" to keep someone alive by using machinery when they're "not going to get better";
(6) people "suffering very badly" should be allowed to die;
(7) "if she became ill and was unable to care for herself she would not want her life to be sustained artificially";
(8) "she would not want to go on living if she could not 'take care of herself and make her own decisions'"; and

48. *In re* Storar, 420 N.E.2d 64 (N.Y. 1981).
49. *Id.* at 73.
50. *In re* Conroy, 486 A.2d 1209 (N.J. 1985).
51. *Id.* at 1218.
52. *Id.* at 1219-44.

(9) she hoped that she would never have to be in a hospital again and "would never want any sort of intervention[,] any sort of life support systems to prolong her life."[53]

The patient, however, had not specifically discussed removing food and water or the possibility that withdrawing medical treatment might lead to a painful death. The *O'Connor* court professed that a patient had the right to decline life-saving medical treatment. But under these circumstances, the court held that the evidence of the patient's desire not to prolong her life was not clear and convincing.

The court claimed that it recognized a common-law right to refuse treatment, but refused to honor O'Connor's own statements and the family's wishes to withdraw treatment. The court held that the wishes of the patient were not clearly expressed. And the court rejected the substituted judgment approach:

> because it is inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another. Consequently, we adhere to the view that, despite its pitfalls and inevitable uncertainties, the inquiry must always be narrowed to the patient's expressed intent, with every effort made to minimize the opportunity for error.[54]

The odd reasoning here tracks that of the health care professionals.[55] The New York court suggests that no person or court should substitute judgment for the patient, but the court is doing just that by substituting its own judgment. If someone is going to substitute judgment for a patient, the family would usually be a better surrogate decisionmaker than the state. To best preserve the patient's own wishes and own conception of what quality of life suffices, we should look to what the patient said or what that patient probably wanted. Any other strategy substitutes the state's judgment for the patient's.

In *Cruzan*, the Supreme Court of Missouri held that the state's interest in preserving life was paramount,[56] at least where Nancy Cruzan's wish not to be kept alive was not proved by clear and convincing evidence. The evidence tended to show that Cruzan had seriously and repeatedly stated that she did not want to be kept alive if she were a "vegetable" and that it was good that others had died rather than lingered on in seriously impaired states:

(1) "Nancy said she would never want to live [in a vegetative state] because if she couldn't be normal or even, you know, like half way, and do things for yourself, because Nancy always did, that she didn't want to live . . . and we talked about it a lot";

(2) Cruzan said "several times" that "she wouldn't want to live that way because if she was going to live, she wanted to be able to live, not to just

53. *O'Connor*, 531 N.E.2d at 610-11.
54. *Id.* at 613 (citation omitted).
55. *See supra* part II.A.
56. Cruzan v. Harmon, 760 S.W.2d 408, 424 (Mo. 1988).

lay in a bed and not be able to move because you can't do anything for yourself";
(3) Cruzan "said that she hoped that [all the] people in her family knew that she wouldn't want to live [as a vegetable] because she knew it was usually up to the family whether you lived that way or not";
(4) Cruzan "said that maybe it was part of a 'greater plan' that [a] baby had been stillborn and did not have to face 'the possible life of mere existence'";
(5) After her grandmother died, Cruzan said that "it was better for my grandmother not to be kind of brought back and forth [by] medical [treatment], brought back from a critical near point of death";
(6) According to Cruzan's sister, Cruzan's mother, and another of Cruzan's friends, "Nancy would want to discontinue the hydration and nutrition";
(7) Cruzan's sister said that "Nancy would be horrified at the state she is in"; that Cruzan would "want to take that burden away from" her family; and that based on "a lifetime of experience [I know Nancy's wishes] are to discontinue the hydration and the nutrition"; and
(8) According to Cruzan's mother, "Nancy would not want to be like she is now. [I]f it were me up there or [her sister] or any of us, she would be doing for us what we are trying to do for her. I know she would, . . . as her mother."[57]

But Nancy Cruzan's evidence was not formalized in a living will; thus it was ignored. In upholding Missouri's decision, Chief Justice Rehnquist argued that this was something like the will requirement for passing property at death—wishes are occasionally frustrated by a general rule requiring strict formalities.

Yet the analogy is inapposite. Will formalities are constantly criticized as frustrating testators' intent;[58] their formalism is considered anachronistic. But more important, the default rule in wills is an intestate distribution scheme that is designed to reflect what people do in wills.[59] In end-of-life decisions, the default rule is the opposite of what would be chosen by the individual.

In *Cruzan* the United States Supreme Court affirmed Missouri's decision,[60] holding that the U.S. Constitution didn't prohibit Missouri from imposing a high standard of proof before honoring the right to die. As a matter of constitutional law, I won't question the decision (at least in print). Whether the state has the power to adopt perverse and stupid rules limiting the liberty of its citizens can't be answered by direct reference to the language of the Constitution. One can resort only to the intellectual swamp that the Supreme Court has created over

57. Cruzan v. Missouri Dep't of Health, 497 U.S. 261, 269-70, 321 (1990).
58. *See* John H. Langbein, *Substantial Compliance With the Wills Act*, 88 HARV. L. REV. 489 (1975).
59. *See* JESSE DUKEMINIER & STANLEY M. JOHANSON, WILLS, TRUSTS AND ESTATES 91 (3rd ed. 1984); Mary L. Fellows et al., *Public Attitudes About Property Distribution at Death and Intestate Succession Laws in the United States*, AM. B. FOUND. RES. J. 319 (1978).
60. *Cruzan*, 497 U.S. at 282-87.

the last 200 years. I fear that if I start wandering around in that swamp, I would fall in and sink. I might fall into a different hole than Rehnquist, O'Connor, and Scalia did, but sink I surely would.

But the majority doesn't say that Missouri's rule is a stupid one that they feel compelled to respect. On the contrary, they think it a good rule. Here they are stepping onto turf that I do intend to explore. What default rule should a state adopt when dealing with the hopelessly ill or unconscious?

In the *Busalacchi* case decided after *Cruzan*,[61] the father and guardian of a patient tried to move his daughter from Missouri (with its punitive laws) to Minnesota with laws more favorable to withdrawing his daughter's feeding tube. She had spent three years in a persistent vegetative state[62] after an automobile accident. The court ruled that the record was not sufficient to support moving her to Minnesota. Treatment continued.

That most appellate decisions have nonetheless allowed death by one means or another doesn't mean that the system is working. In almost all of these cases, life was prolonged beyond the point most patients would want—at great cost and potential damage to survivors with little or no corresponding benefit. If doctors understood the default rule as death and families were informed of probable patient preferences for death, the system might operate much more smoothly, with less cost and agony over what the patient would have wanted.

III

DEFAULT RULES

The idea of default rules is one of the most powerful heuristics in the recent law and economics and legal philosophy literature. In some form, the idea of default rules has been with us for centuries. In the law of succession, for example, when someone dies without a will, the estate passes by intestacy. The general theory behind intestacy has long been considered the probable intent of the decedent. The intestate distribution scheme is the default setting. Those who want to avoid the default setting must make their desires clear in a will.

It is in contracts that the concept of default rules has achieved its highest flowering. The use of contract default rules has been explored in a series of articles and books by Ayres and Gertner;[63] Baird;[64] Barnett;[65] Coleman,

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61. *In re* Christine Busalacchi, 1991 Mo. App. Lexis 315 (Mo. App. 1991).

62. That was her diagnosis, but there was conflicting evidence on whether the diagnosis was correct.

63. Ian Ayres & Robert Gertner, *Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules*, 99 YALE L.J. 87 (1989).

64. Douglas G. Baird, *Self-Interest and Cooperation in Long-Term Contracts*, 19 J. LEGAL STUD. 583 (1990).

65. *See, e.g.*, Randy E. Barnett, *The Sound of Silence: Default Rules and Contractual Consent*, 78 VA. L. REV. 821 (1992).

Heckathorn, and Maser;[66] Craswell;[67] Easterbrook and Fischel;[68] Gillette;[69] Goetz and Scott;[70] Haddock, Macey, and Machesney;[71] Johnston;[72] Kull;[73] and Schwartz.[74]

A default rule is a background rule that people may opt out of, a rule that applies in the absence of a particular expressed preference. Thus when I suggest that the default rule should be death in many end-of-life situations, I am not trying to expand the types of medical conditions that can lead to the withdrawal of treatment, nor am I asking doctors to do anything that they wouldn't do if they had good evidence of the patient's wishes. Rather, I am asking them to give the same treatment to those who can't speak as they give to those who can.

The two leading camps in default-rule analysis are the philosophical school that seeks the intent of the parties,[75] and the law and economics school that seeks sound social policy in the form of wealth or utility maximization (which may[76] or may not[77] seek the intent of the parties). My purpose here is not to choose between these various sources for the content of decision rules; rather, it is only to point out that, whichever of these sources is chosen, the default rule ought to be death for at least some important classes of end-of-life situations. Utility maximization, however, might lead to a different result in one case: if the family wishes that the patient be kept alive when the patient would want treatment withdrawn, intent analysis might point toward withdrawing treatment while utility analysis might point toward keeping the patient alive because that would make the family happier. I don't analyze the default rule under the myriad of moral philosophies that are more absolute or content-directive than liberty, efficiency, or utility approaches.

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66. Jules L. Coleman, Douglas D. Heckathorn & Steven M. Maser, *A Bargaining Theory Approach to Default Provisions in Contract Law*, 12 HARV. J.L. & PUB. POL'Y 637 (1989).

67. Richard B. Craswell, *Contract Law, Default Rules, and the Philosophy of Promising*, 88 MICH. L. REV. 489 (1989).

68. FRANK H. EASTERBROOK & DANIEL R. FISCHEL, THE ECONOMIC STRUCTURE OF CORPORATE LAW (1991).

69. Clayton P. Gillette, *Commercial Relationships and the Selection of Default Rules for Remote Risks*, 19 J. LEGAL STUD. 535 (1990).

70. Charles J. Goetz & Robert E. Scott, *The Limits of Expanded Choice: An Analysis of the Interactions Between Express and Implied Terms*, 73 CALIF. L. REV. 261 (1985); Robert E. Scott, *A Relational Theory of Default Rules for Commercial Contracts*, 19 J. LEGAL STUD. 597 (1990).

71. David D. Haddock, Jonathan R. Macey & Fred S. McChesney, *Property Rights in Assets and Resistance to Tender Offers*, 73 VA. L. REV. 701 (1987).

72. Jason S. Johnston, *Strategic Bargaining and the Economic Theory of Contract Default Rules*, 100 YALE L.J. 615 (1990).

73. Andrew Kull, *Mistake, Frustration, and the Windfall Principle of Contract Remedies*, 43 HASTINGS L.J. 1 (1991).

74. Alan Schwartz, *Proposals for Products Liability Reform: A Theoretical Synthesis*, 97 YALE L.J. 353, 361 (1988).

75. *See* Barnett, *supra* note 65, at 821.

76. *See* Goetz & Scott, *supra* note 70, at 261; Schwartz, *supra* note 74, at 361; FRANK EASTERBROOK & DANIEL FISCHEL, THE ECONOMIC STRUCTURE OF CORPORATE LAW (1991); Jordan v. Duff & Phelps, 815 F.2d 429, 436 (7th Cir. 1987) (Easterbrook, J.); *id.* at 446-67 (Posner, J., dissenting).

77. *See* Ayres & Gertner, *supra* note 63, at 94.

IV

WHAT PEOPLE WANT

Consent is the central organizing principle of the decision to undergo medical treatment. In desperate end-of-life situations, courts shouldn't have the power to order treatment when a person has not consented to treatment and probably wouldn't if competent. If we were to model a legal default rule for withdrawing life-sustaining treatment based on the wishes of the patient, we should consider what patients in that situation would probably want and honor those wishes as if actually expressed. Here there are two sources for determining people's wishes for withholding treatment, besides what a particular individual might have said or written before losing the power to communicate: opinion polls and advance directives, such as living wills. Both point in the same direction.

A. Using Polls

1. *Individual Preferences as Revealed in Polls.* Medicine's ability to keep patients more or less alive for years in a coma or persistent vegetative state has robbed death of its certainty. Machines can provide food, hydration, and respiration to those who would die without them. This greatly increases the possibility that people can survive lengthy periods unconscious, semi-conscious, or demented and deteriorating from terminal illnesses. People have responded to this growing contact with degraded and lengthy deaths with a realization that they don't want to go through this themselves.

I reviewed over 200 national opinion poll questions involving end-of-life decisions.[78] Most asked questions about the *right* to die, rather than the treatment decision patients themselves would want. Only a handful asked directly whether people themselves would want to be allowed to die. As the following seven tables indicate, most people would not want to be kept alive if they were on life support systems or in a coma.

Table 1
Preference for Withdrawing Life Support

If you, yourself, were on life support systems and there was no hope of recovering, would you like to remain on the life support system or would you like treatment withheld so that you could end your life?

Treatment Withheld	84%
Kept on Life Support	9
No opinion	7

SOURCE: GALLUP POLL, 1990

78. *See* Appendix for a selection of polls.

Table 2
Preference for Withdrawing Feeding Tube

Suppose you were in a coma with no brain activity and were being kept alive by a feeding tube. Would you want your doctor to remove the feeding tube and let you die, or not?

Want removal of feeding tube	85%
Would not want tube removed	11
Don't know/No answer	4

SOURCE: CBS NEWS/NEW YORK TIMES, 1990

Table 3
Preference for Withdrawing Food and Water

If you, yourself, were terminally ill or in irreversible coma, would you want life support systems, including food and water, withdrawn or not?

Yes	73%
No	21
Unsure	7

SOURCE: GALLUP ORGANIZATION FOR THE AMA, 1990

Table 4
Preference for Stopping Treatment if Totally Dependent

How about if you had an illness that made you totally dependent on a family member or other person for all of your care? (Repeat if necessary: Would you tell your doctor to do everything possible to save your life, or would you tell your doctor to stop treatment?)

Stop treatment	51%
Save life	31
It depends (volunteered)	7
Don't know	11

SOURCE: PRINCETON SURVEY RESEARCH ASSOCIATES FOR THE TIMES MIRROR, 1990

Table 5
Preference for Stopping Treatment if in Great Pain

Now, I'm going to describe a few medical situations that sometimes happen, and for each one, please tell me what you would want your own doctor to do, if you could make the choice. If you had a disease with no hope of improvement and you were suffering a great deal of physical pain, would you tell your doctor to do everything possible to save your life, or would you tell your doctor to stop treatment so you could die?

Stop treatment	59%
Save life	28
It depends (vol.)	6
Don't know	7

SOURCE: PRINCETON SURVEY RESEARCH ASSOCIATES FOR THE TIMES MIRROR, 1990

Table 6
Preference for Withdrawing Treatment if in Coma

Imagine you were in a coma with no hope of recovery, were suffering no pain, and had left no instructions to your family or closest friend stating your wishes. Would you want them to ask your doctor to withdraw life-sustaining treatment, or would you not?

Yes, I would	75%
No, I would not	17
Something else (vol.)	2
Don't know	6

SOURCE: KRC COMMUNICATIONS/RESEARCH FOR THE KAISER FOUNDATION, 1991

Table 7
No Clear Preference if Disease Makes it Hard to Function

How about if you had a disease with no hope of improvement that made it hard for you to function in your day-to-day activities? (Repeat if necessary: Would you tell your doctor to do everything possible to save your life, or would you tell your doctor to stop treatment?)

Stop treatment	44%
Save life	40
It depends (volunteered)	8
Don't know	8

SOURCE: PRINCETON SURVEY RESEARCH ASSOCIATES FOR THE TIMES MIRROR, 1990

Only the last situation, "a disease with no hope of improvement that made it hard for you to function in your day-to-day activities," received less than 50% preference for withdrawing treatment. Even then, a plurality supported the withdrawal of treatment. This last result is unclear primarily because the question is unclear. To me, it covers not only a desperately ill helpless patient (who might reasonably choose death) but also a fully competent, hard-working degenerative arthritic (who finds it "hard to function in . . . day-to-day activities").

With this one (sound) exception, the polls show overwhelmingly that people would not want to be kept alive on life-support systems (including food and water) if they are terminally ill, in a coma, or in great pain. This result is generally consistent with other polls. In his dissent in *Cruzan*,[79] Justice Brennan described two other polls:

> A 1988 poll conducted by the American Medical Association found that 80% of those surveyed favored withdrawal of life support systems from hopelessly ill or irreversibly comatose patients if they or their families requested it. New York Times, June 5, 1988, p. 14, col. 4 (citing American Medical News, June 3, 1988, p. 9, col. 1).

79. Cruzan v. Missouri Dept. of Health, 497 U.S. 261, 312 n.11 (1990) (Brennan, J., dissenting).

> Another 1988 poll conducted by the Colorado University Graduate School of Public Affairs showed that 85% of those questioned would not want to have their own lives maintained with artificial nutrition and hydration if they became permanently unconscious. The Coloradoan, Sept. 29, 1988, p. 1.[80]

Note the similarity in the numbers despite the differences in the questions. Six of the nine polls mentioned so far favor withdrawing treatment in the range of 73-85%. There are dozens of other polls showing support for the right to die in roughly the same range.[81]

For difficult policy decisions, it's often better to look at poll data or treatment choices of those who have the most knowledge of the problem (such as doctors) or those who have given it the most thought (such as the elderly or nursing home residents). Tables 79-81 show physician preferences against treatment for themselves.[82]

Table 79
Physician Preference Against CPR if Terminally Ill

Assume that you developed a terminal illness which has progressed and caused your heart to stop beating. Given these circumstances, you would want CPR.

Strongly Agree, Agree, or No Strong Feelings	14%
Strongly Disagree or Disagree	86

SOURCE: BRUNETTI, CARPEROS & WESTLUND STUDY, 1989

Table 80
Physician Preference Against CPR if Mentally Incompetent and Terminally Ill

Assume that you are mentally incompetent suffering from a terminal illness which has caused your heart to stop beating. Given these circumstances, you would want CPR.

Strongly Agree, Agree, or No Strong Feelings	7%
Strongly Disagree or Disagree	93

SOURCE: BRUNETTI, CARPEROS & WESTLUND STUDY, 1989

80. *Id.* (citations omitted).
81. *See, e.g.,* Appendix Tables 16-27.
82. Louis L. Brunetti et al., *Physicians' Attitudes Towards Living Wills and Cardiopulmonary Resuscitation,* 6 J. GEN. INTERNAL MED. 323, 327 (1991).

Table 81
Physician Preference Against Feeding if Unconscious and in PVS

If you became permanently unconscious in a persistent vegetative state and could not eat normally, you would want your life maintained through artificial feedings.

Strongly Agree, Agree, or No Strong Feelings	8%
Strongly Disagree or Disagree	92

SOURCE: BRUNETTI, CARPEROS & WESTLUND STUDY, 1989

One study of the preferences of nursing home patients found that patients had "clear and consistent patterns of preferences regarding the utilization of life-sustaining treatment." Generally, participants "opted not to be treated."[83] Because the study weighted the strength of the responses, the exact numbers preferring to withhold treatment can't be directly gleaned from the published data. But the weighted averages supported the withdrawal of treatment from nursing home residents in the following situations, no matter what the level of cognitive functioning at time of treatment (intact, confused, or unconscious): tube feeding (both temporary and permanent), resuscitation, amputation, and using a respirator.[84] Interestingly, those who had had previous experience with life-support treatment were less likely to want to be kept alive by life support.[85]

Another study[86] of nursing home residents reached similar results:

Table 82
Competent Nursing Home Residents' Preference Against Life-Sustaining Treatment

If you were about to die of natural causes, would you want us to keep you alive by drugs, fluids, food by tubes, breathing machines, and heart massage?

Yes	26%
No	68
Delay	5

SOURCE: DIAMOND, JERNIGAN, MOSELEY, MESSINA, & MCKEOWN STUDY, 1989

83. Jiska Cohen-Mansfield et al., *The Decision to Execute a Durable Power of Attorney For Health Care and Preferences Regarding the Utilization of Life-Sustaining Treatments in Nursing Home Residents,* 151 ARCHIVES INTERNAL MED. 289 (1991).

84. *Id.* at 291-92.

85. *Id.* at 293 (59% would not want treatment, 8% would want treatment, 28% would not want treatment if cognitive functioning impaired; differences with general population were apparently not significant).

86. Eric L. Diamond et al., *Decision-Making Ability and Advance Directive Preferences in Nursing Home Patients and Proxies,* 29 GERONTOLOGIST 622 (1989) (a study of 75 elderly nursing home patients in Pitt County, North Carolina).

One study of community-dwelling elderly persons directly examined the influence of question framing on patient preferences.[87] It found that, by framing questions about the treatment options in positive or negative terms, the percentages preferring life-sustaining treatment could be manipulated. Yet, even when the treatment options of CPR, ventilation, or nutrition and hydration were described in positive terms, only 26.9-33.7% wanted treatment. Subjects consistently preferred to have treatment withheld (CPR, ventilation, and nutrition and hydration), no matter how the question was framed, if they would later suffer from dementia (14.2-30.6% wanted treatment), persistent vegetative state (13.6-33.7% wanted treatment), or stroke (8.5-26.9% wanted treatment).

A study[88] of elderly patients found that the elderly preferred withholding treatment in the following situations:

> (1) Elderly persons would not want to have their pneumonia treated with antibiotics if they were conscious, confused, lacked basic bathroom skills, and were able to experience both pleasure and fear;
>
> (2) Elderly persons would not want to be resuscitated if they were in a coma from which they had a 50-50 chance of regaining consciousness and had a heart attack, when if resuscitated there was a strong possibility that they would never leave the hospital;
>
> (3) Elderly persons would not want a pacemaker implanted if after a patient arranged for an operation she had a stroke, leaving her partially paralyzed, unable to feed or bathe herself, and mentally confused, where the pacemaker would probably prolong her life for many years and bankrupt her small estate;
>
> (4) Elderly persons would not want an otherwise necessary blood transfusion if they were very confused by a series of strokes, lacked basic bathroom skills, and were able to enjoy their daily experiences but became easily frightened.[89]

A study of people in a retirement community who already had living wills revealed that if terminally ill they would not want CPR, a respirator, a nasogastric feeding tube, or intravenous fluids.[90] Retirees were ambivalent about antibiotic therapy and would want oxygen for comfort.

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87. Timothy R. Malloy et al., *The Influence of Treatment Decisions on Advance Medical Directive Decisions*, 40 J. AM. GERIATRIC SOC'Y 1255 (1992).

88. Tomlinson et al., *supra* note 25.

89. *Id.* at 57, 61-64.

90. Martha Henderson, *Beyond the Living Will*, 30 GERONTOLOGIST 480, 482 (1990) (depending on the treatment in question, responses ranged from 74.6% to 92.1% rejecting treatment).

Table 83
Retirees' Preference If Terminally Ill

	Yes	Undecided or Qualified	No
Want CPR	0%	22.2%	77.8%
Want respirator	0	7.9	92.1
Want nasogastric tube feeding	1.6	9.5	88.9
Want intravenous fluids	6.3	19.1	74.6
Want oxygen for comfort	65.1	14.3	20.6
Want antibiotic therapy	23.8	34.9	41.3

SOURCE: HENDERSON STUDY, 1990

Another area of ambivalence is in the treatment of AIDS patients. One study of AIDS patients found that they would want to be resuscitated.[91] Another study found that they would want to be hospitalized and treated for pneumonia (95%), but opinions on ventilation (55%) and CPR (46%) were mixed.[92] If the condition deteriorated to severe memory loss and severe pneumonia, only 19% wanted ventilation and 17% wanted CPR.[93]

So far I have spoken only about withdrawing active treatment, not about physician-assisted suicide by lethal injection or otherwise. This is more controversial. In polls, a majority of persons favor physician-assisted suicide where patients want it.[94]

Table 57
Preference for Active Euthanasia, 1947-1991
When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?

	1991	1990	1989	1988	1986	1985	1983	1982	1978	1977	1973	1947
Yes	70	69	66	66	66	64	63	61	58	60	53	37
No	25	26	30	29	31	33	33	34	38	36	40	54
Don't know	5	5	4	5	4	3	4	5	4	4	7	9

BY: NATIONAL OPINION RESEARCH CENTER (1977-91); GALLUP ORGANIZATION (1947-73)
SOURCE: GENERAL SOCIAL SURVEY (1977-91); GALLUP POLL (1947-73)

91. See Jennifer S. Haas et al., *Discussion of Preferences for Life-Sustaining Care by Persons With AIDS*, 153 ARCHIV. INTERN. MED. 1241, 1245 (1993) (174 Boston patients want resuscitation; 113 patients don't).

92. Robert Steinbrook et al., *Preferences of Homosexual Men With AIDS for Life-Sustaining Treatment*, 314 NEW ENG. J. MED. 457, 458 (1986).

93. *Id.*

94. *See* Appendix Tables 56-65.

What is interesting about the dozen polls displayed in Table 57 is that there was a reversal between 1947 and 1977 in public opinion polls about medically-assisted suicide. In the 15 years since 1977, the consensus favoring suicide has grown even stronger. Nonetheless, a proposal to allow this in Washington was narrowly defeated in the November 1991 election,[95] after a heated campaign. A somewhat similar proposal to amend the California right-to-die statute to permit physician-assisted suicide was defeated in November 1992.[96]

Nor do most people fear death.[97] Those who don't believe in an afterlife have little to fear.[98] Those over 50 fear death less,[99] although they are closest to death, have a higher mortality rate, and have had more of their life to think about it. And most who believe in an afterlife think they have a good chance of going to heaven.[100]

2. *Problems with Polls.* One must not be too sanguine about the data in Table 1 showing a desire to avoid treatment. First, even if most people wouldn't want to be kept alive on life support systems, perhaps there are subgroups within the population that feel differently—regular church-goers, Catholics, born-again Christians, or older people.[101] Perhaps the state should have a different presumption for them. In Table 8, I break down the data in Table 1, revealing

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95. Initiative 119 was defeated 810,623 to 701,808. It would have granted "the right to death with dignity through voluntary aid-in-dying if suffering from a terminal condition." This particular right would be exercisable only if the patient executed an advance directive.

96. *Suicide Aid Focus Turns to California*, LOS ANGELES TIMES, Nov. 7, 1991, at A-3; *Vote Totals on Measures Were Wrong*, LOS ANGELES TIMES, Nov. 11, 1992, at B-1 (Proposition 161 defeated 5,381,128 to 4,529,829).

97. Gallup Poll, GALLUP POLL MONTHLY 52 (Jan. 1991) (poll conducted 1990) (23% fear death).

98. *Id.* (27% don't believe in life after death; 32% don't believe in Hell).

99. *Id.* (fear of death—age 50+ (16%), age 30-49 (25%), age 18-29 (33%)).

100. *Id.* (77% think that they have an excellent or good chance of going to heaven).

Although poll data show that neither those who believe in heaven, nor those who don't, fear death, the reason that the nonreligious are unafraid of death is open to speculation. Leonardo Da Vinci believed that "a life well spent brings happy death." Similar views were held by many Enlightenment thinkers, including Condorcet, most pragmatists, and such philosophers as Bertrand Russell. On the other hand, some philosophers, particularly existentialists, have urged that we cultivate an awareness of death as a way to live a fuller life. *See* JACQUES CHORON, DEATH AND WESTERN THOUGHT (1963); Robert G. Olson, *Death*, 2 ENCYCLOPEDIA OF PHILOSOPHY 307, 308 (1967).

Among those philosophers expressing a fear of death are the Spanish existentialist, Miguel de Unamuno: "As a youth and even as a child, I remained unmoved when shown the most moving pictures of hell, for even then nothing appeared to me quite so horrible as nothingness itself." Robert G. Olson, *supra*, at 308. Here, as elsewhere, it appears that existentialists think differently than the rest of us. Not only are Americans unafraid of death, but they also don't think about it much. Gallup Poll, GALLUP POLL MONTHLY 51 (Jan. 1991) (1990 poll) (7% think about it very often; 9% think about it somewhat often).

101. On the religious arguments about dying, see THOMAS C. OGDEN, SHOULD TREATMENT BE TERMINATED? 61-89 (1976); UNITED CHURCH OF CHRIST, THE RIGHT TO DIE (1973); Isaac Franck & Richard A. McCormick, *Moral Dilemmas That are Acute Within a Religious Tradition: A Jewish Perspective; A Catholic Perspective*, 18 HOSP. PRAC. 192 (1983); Gilbert Meilander, *The Distinction Between Killing and Allowing to Die*, 37 THEOLOGICAL STUD. 467 (1976); Bernard Ramm, *A Christian Definition of Death*, 25 J. AM. SCI. AFFILIATION 56, No. 2 (1973); Robert B. White & H. Tristram Engelhardt, *A Demand to Die: Case Studies in Bioethics*, 5 HASTINGS CENTER REPORT 9, No. 3 (June 1975).

even more clearly that Americans don't want to be kept alive on life support, regardless of religion, age, sex, race, or fear of death.

Table 8
Preference for Withholding Treatment
Broken Down by Demographics

If you, yourself, were on life support systems and there was no hope of recovering, would you like to remain on the life support system or would you like treatment withheld so that you could end your life?

	Kept on life support	Treatment withheld	No opinion
TOTAL:	9%	84%	7%
Age:			
18-29	11	85	4
30-49	8	84	8
50 or older	9	82	9
Does getting older bother you?:			
A great deal	17	70	14
Somewhat	9	87	5
Not at all	8	84	8
Fear of death:			
Yes, fear death	11	83	6
No, don't fear death	8	84	8
Thinking about death:			
Very often or somewhat often	7	5	8
Every now & again or almost never	9	83	7
Religion:			
Protestant	9	84	8
Catholic	8	85	7
Jew	9	91	0
None	10	80	11
Born-Again Christian:			
Yes, born-again	9	84	7
No, not born-again	8	85	7
Church/Synagogue Member:			
Yes, church/synagogue member	9	84	8
No, not c/s member	9	84	7

Table 8 (continued)

	Kept on life support	Treatment withheld	No opinion
Attended church in last 7 days:			
Yes, attended church	10	82	9
No, didn't attend church	8	85	6
Sex:			
Male	11	82	7
Female	7	85	8
Education:			
College Graduate	9	82	9
Some College	10	83	7
High-School Graduate	9	86	5
Less Than H-S Graduate	7	82	12
Education by Sex:			
College Male	13	79	8
College Female	6	86	8
Noncollege Male	9	85	6
Noncollege Female	8	85	7
Race:			
White	7	87	6
Black	19	64	17
Other	25	71	5
Region:			
East	14	78	8
Midwest	7	87	6
South	8	83	10
West	6	88	7
Income:			
$50,000 +	8	89	3
$30,000-49,900	10	86	5
$20,000-29,900	5	86	9
Under $20,000	11	83	7
Political Party:			
Republican	9	84	7
Democratic	11	82	7
Independent	7	86	8
Ideology:			
Liberal	8	86	6
Moderate	6	91	3
Conservative	9	84	7

BY: GALLUP ORGANIZATION
SOURCE: GALLUP POLL, 1990 (demographic data previously unpublished)

As Table 8 shows, there is little difference between various social, political, and religious groups in their preferences for withholding treatment. Contrary to what some people might expect, Catholics, born-again Christians, regular church-goers, and older people aren't more likely than the general population to want to be kept alive on life support systems. Of the 47 demographic groups broken down in the poll, none had less than 64% preferring the withholding of life support or more than 25% wanting to be kept alive. The smallest ratio preferring death was nearly 3 to 1 (71% to 25% for nonwhites other than blacks); the largest ratio was 17 to 1.[102] Only 3 subgroups had more than 14% desiring to be kept alive—blacks (19%), other nonwhite races (25%), and those bothered a great deal by getting older (17%). Only one subgroup (blacks—64%) had less than 70% favoring the removal of life support. The results are remarkably consistent across subgroups, so consistent that the small differences between subgroups may be due to chance. Other studies have found similar results for the highly religious; they are no different in their treatment preferences.[103]

A more profound concern with this polling data is the question itself. In most polls, the responses that people give are highly dependent on how questions are asked. The Malloy study, which examined the influence of question framing on results, found significant differences when the treatments were presented positively or negatively.[104] But the preference for withdrawing treatment was strong regardless of how the question was framed.

The question in Tables 1 and 8 asked what people would want if there were "no hope of recovering." It's true that doctors frequently know with substantial certainty what will happen to a patient. For example, as of 1990, only 3 of 100,000 patients in a persistent vegetative state had ever regained consciousness.[105] Yet to say that there is no hope is to suggest a level of certainty that will sometimes be beyond that achievable. But people answering polls are not stupid. They operate within the same epistomological scheme we all do. They are likely to interpret the phrase about "no hope" as reflecting a doctor's opinion that there is no hope. It would be reasonable to assume that those answering the poll were aware of the impossibility of absolute certainty about the future.

Nonetheless, it would obviously be better for policymakers to explore the level of certainty needed about prognosis, as well as the degree of recovery or good outcome possible. Regaining consciousness with serious brain damage is certainly a possibility for many patients in extended comas, but would most people count this as recovery? The strength of the public's preference for withdrawing life-support suggests that this preference would probably persist as the likelihood and degree of recovery rose, but it's unclear where it would cross the 50% level for some subgroups.

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102. 86% to 5% for incomes $20,000-29,900.
103. Cohen-Mansfield et al., *supra* note 83, at 293.
104. *See* Malloy et al., *supra* note 87.
105. Cruzan v. Missouri Dept. of Health, 497 U.S. 261, 309 n.8 (1990) (Brennan, J., dissenting).

B. Individual Preferences as Revealed in Living Wills, Durable Powers of Attorney for Health Care, and Other Medical Directives

Polls are only one way to reveal individual preferences—and not necessarily the best. Indeed, in determining the proper rules for succession to property at death, polls have proved to be notoriously unreliable. When people were asked in a poll whether parents should be allowed to disinherit their minor children, 93% said no.[106] Yet in Allison Dunham's study of will-making practices in Illinois,[107] he found that in every case in his sample with a surviving spouse and minor children of that marriage, the testator did just that. He or she disinherited the minor children in favor of the surviving parent. Of course, part of the disjunction between the poll and practice is in the wording of the question. People incorrectly assume that disinheriting a child is an act of spite different from merely providing for them by leaving the property in the hands of the child's father or mother.

Yet the lesson here is important. Looking at what people actually do when planning their estate with an attorney may be more reliable than looking at what they say to a pollster. Indeed, the insights of Dunham's work, that people in their wills leave much more to their spouses than the old intestacy rules would have provided, have slowly but effectively worked their way into the most recent intestacy schemes. The intestacy share of the surviving spouse with minor children has moved in the United States from the traditional quarter or third, to more than half in the pre-1990 Uniform Probate Code,[108] to the entire estate in the latest revision of the Uniform Probate Code.

Several studies used actual directives or patients requested that the results of the surveys be put in their charts.[109] Patient preferences for the withdrawal of treatment were shown in each of these studies. In one study, discrepancies between the treatment option on an advanced directive and their survey treatment option were examined.[110] In all six cases of discrepancies, the patient was *more* likely to want treatment withdrawn when the patient actually expected the advance directive to be acted upon.[111]

1. *Living Wills.* Intestacy is the default rule for people who don't leave wills. Although it has taken a long time, the default rule now in the Uniform Probate Code looks like what people usually do when they write wills. What I am suggesting in this article is similar—that the default rule for end-of-life situations

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106. J. COHEN, R. ROBSON & A. BATES, PARENTAL AUTHORITY: THE COMMUNITY AND THE LAW 76-78 (1958).

107. *See* Allison Dunham, *The Method, Process and Frequency of Wealth Transmission at Death*, 30 U. CHI. L. REV. 241, 256 (1963).

108. *See* UNIF. PROB. CODE § 2-101 (1989); *id.* § 2-102 (1990).

109. *See* Cohen-Mansfield et al., *supra* note 83, at 289 (advance directives executed); Diamond et al., *supra* note 86, at 625 (same); Jefferson et al., *supra* note 13, at 901 (same); Henderson, *supra* note 90, at 483 (80% wanted questionnaire to be part of medical record).

110. Diamond et al., *supra* note 86, at 625.

111. *Id.*

should look like what people usually do when they write health care directives,[112] particularly living wills[113] and durable medical powers of attorney.[114] Since December 1, 1991, under the federal Patient Self-Determination Act, hospitals and other facilities must inquire about advance directives when admitting in-patients.[115] They must record the existence of any directives in the patients' charts.

In the 1984 edition of the casebook *Wills, Estates, and Trusts*, Jesse Dukeminier and Stanley Johanson begin their brief discussion of living wills with these words:

> In recent years a document has been created called, rather perversely it seems to us, a *living will*. It contains directives concerning termination of medical treatment, but it possibly could be viewed as an advance disposition of a person's life. The document provides that the signer's life shall not be artificially prolonged by extraordinary measures where there is no reasonable expectation of recovery from extreme physical or mental disability.[116]

This passage is interesting for a number of reasons. First, it explains in part why living wills are covered very little if at all in trusts and estates courses, even though they sound like estate planning to clients.[117] Are they really so different from guardianship provisions? Second, this passage describes what these devices do—direct medical treatment. But the last sentence is the most interesting for my purposes: "The document provides that the signer's life shall

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112. *See* Kent W. Davidson et al., *Physicians' Attitudes on Advance Directives*, 262 JAMA 2415 (1989) (advance directives promote patient autonomy); Linda L. Emanuel, *The Health Care Directive: Learning How To Draft Advance Care Documents*, 39 J. AM. GERIATRICS SOC'Y 1221 (1991) (model directive contains "an instructional section, a durable power of attorney section, a values statement section, and an organ donation section in addition to the illness scenarios section"); Linda L. Emanuel & Ezekiel J. Emanuel, *The Medical Directive: A New Comprehensive Advance Care Document*, 261 JAMA 3288 (1989); Kenneth V. Iserson, *Getting Advance Directives to the Public: A Role for Emergency Medicine*, 20 ANNALS EMERGENCY MED. 692 (1991) ("Only 9% of Americans have executed advance directives."); Jan Hare & Carrie Nelson, *Will Outpatients Complete Living Wills? A Comparison of Two Interventions*, 6 J. GENERAL INTERNAL MED. 41 (1991) (study of use of advance directives).

113. Note, *Comparison of the Living Will Statutes of the Fifty States*, 14 J. CONTEMP. L. 105 (1988); David J. Doukas et al., *The Living Will: A National Survey*, 23 FAM. MED. 354 (1991) (study of living will practices); John A. Robertson, *Second Thoughts on Living Wills*, 21 HASTINGS CENTER REP. 6, No. 6 (1991). In 1990, there were 40 states (and the District of Columbia) with living wills laws. National Legal Center Staff, *Medical Treatment for Older Persons and Persons with Disabilities: 1990 Developments*, 6 ISSUES LAW MED. 341 (1991).

114. Susan R. Martyn & Lynn Balshone Jacobs, *Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney*, 63 NEBR. L. REV. 779 (1984); Jiska Cohen-Mansfield et al., *The Utilization Of The Durable Power Of Attorney For Health Care Among Hospitalized Elderly Patients*, 39 J. AM. GERIATRICS SOC'Y 1174 (1991).

115. Omnibus Budget Reconciliation Act of 1990, §§ 4206 & 4751, Pub. L. No. 101-508 (1990); Theresa Hudson, *Hospitals Work to Provide Advance Directives Information*, 65 HOSPITALS 26 (Feb. 5, 1991); Elizabeth McCloskey, *Between Isolation and Intrusion: The Patient Self-Determination Act*, 19 LAW, MED. & HEALTH CARE 80 (1991).

116. DUKEMINIER & JOHANSON, *supra* note 59, at 283 (footnotes omitted).

117. The Health Care Group, *Preparation for Incapacity Essential to Plan*, 94 PA. MED. 40 (May 1991) ("Without . . . [a durable general power of attorney and a living will] your [estate] plan is not complete.").

not be artificially prolonged . . . ."[118] Dukeminier and Johanson state the plain truth. Although these living wills can theoretically be used to prolong life, overwhelmingly these direct that life shall not be prolonged artificially. Indeed, realistically, that's their purpose—to direct the withholding of treatment.

Almost all living wills direct the withholding of care, not the prolongation of life.[119] In one study, researchers compared elderly preferences (86%) for withdrawing treatment in terminal illnesses with the state's living will statute and found that they were consistent: "We conclude that living will legislation is congruent with the desire of many elderly persons to limit medical care in terminal illness."[120] Other studies of attitudes toward living wills have similarly concluded that most patients "opted to forego burdensome measures when death appeared imminent."[121]

One criticism that might be raised against my analysis here is that, by making a living will, a person is opting out of the default rule. Why base decisions on people who opt out of the default rule rather than on those who agree with it and do nothing? Yet a similar criticism was made of using the Dunham study to remake the law of intestacy. And there this objection was ultimately rejected. Perhaps policy makers thought that people who make wills are not so different from other people, though they're certainly richer. Also, there are several reasons that one might want to make a will besides opting out of the intestacy scheme, such as choosing a guardian for your children, choosing an executor, waiving the bond or surety, or reducing taxes.

Likewise, in end-of-life situations there are reasons for making a living will that go beyond a decision to opt out of the default rule. First, the default rule here is far more muddled than in intestacy. There is considerable confusion about just what the default rule is among the general public. If your family or the doctor decides to pull the plug, will the courts or the hospital hierarchy allow it? This confusion arises in part because some courts and hospitals emphasize what the patient wanted, while others use a substituted judgment model that leaves the choice to the family or a guardian, while still others use a best interests model (which may do what the state wants). All those models are greatly affected by the prognosis. If a bad outcome is almost certain, most courts have actually allowed treatment to be stopped. Thus, if you would want life aggressively preserved but your family wouldn't, without a living will, you greatly reduce your chances of receiving the benefits of the default rule. Further, many people would want to relieve their family of the burden of choosing even if they thought that the family would ultimately choose the same treatment that they would.

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118. *See supra* text accompanying note 116.

119. *See supra* notes 83-86, 90, 109 and accompanying text.

120. Elizabeth R. Gamble et al., *Knowledge, Attitudes, and Behavior of Elderly Persons Regarding Living Wills*, 151 ARCHIVES INTERNAL MED. 277, 279 (1991).

121. Diamond et al., *supra* note 86.

Perhaps a stronger argument against viewing those who opt out of the system as grossly unrepresentative of the majority is that most people want living wills. Stated another way, most people would want to opt out of the default rule at least to the point of making a living will. About 4 to 24% of Americans have a living will.[122] According to a Gallup Poll, among the approximately 80% who don't, 75% want one.[123] Thus about 80% of the population have a living will or want one; only about 14% don't want one.[124] Unless those who want a living will look completely different from those who have one (and there's some evidence that they're similar[125]) a great majority of the population either has or would like to have a living will that provided for withholding treatment in at least some significant situations.

2. *Durable Powers of Attorney for Health Care and Other Advance Directives.* Living wills are falling out of favor in the academic community. There are two related reasons: Living wills can't foresee all of the possible situations that might arise, and living wills typically are too narrow to cover many of the easily foreseeable situations.[126] Durable powers of attorney for health care are another means of resolving treatment problems in end-of-life situations. Some commentators prefer living wills; others prefer durable medical powers of attorney; others prefer hybrid medical directives.[127] For safety, I think that people should have the hybrid medical directive or both of the other directives.

Living wills state the patient's wish to withhold treatment. Powers of attorney are formalized agency relationships appointing another person, an *agent* or *attorney-in-fact* (who is not usually a lawyer), to make decisions for them. These may be limited to particular duties or decisions (for example, medical decisions or investment decisions) or they may be general. An ordinary power of attorney ceases at death or incompetency, like most agency relationships. To fill this void, all fifty states have enacted legislation allowing individuals to execute *durable* powers of attorney, which continue into incompetency but cease

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122. *See* Tables 66-70 in Appendix (15-24% have living wills); Dallas M. High, Howard B. Turner, *Are Kentuckians Using Advance Medical Directives?,* 89 J. KY. MED. ASS'N 546 (1991) (9% of Kentuckians have living wills; 9% have durable powers for health care); Iserson, *supra* note 112, at 692 ("Only 9% of Americans have executed advance directives."); Allen S. Joseph & Charles E. Grenier, *The Right to Die: Public Perceptions and Attitudes in Metropolitan Baton Rouge,* 142 J. LA. STATE MED. SOC'Y 18 (Nov. 1990) (less than 4% have executed living wills).

123. Gallup Poll, GALLUP POLL MONTHLY 56 (Jan. 1991) (1990 poll) ("If you don't have a living will, would you like to have one?"—Yes (75%), No (17%), No Opinion (8%)).

124. *Id.*

125. Roberta Ann Smith et al., *Measuring Desire for Control of Health Care Processes,* 47 J. PERSONAL SOC. PSYCH. 415, 422 n.6 (1984) (both groups similar); Cohen-Mansfield et al., *supra* note 83, at 292 (Those executing durable powers during the study were more likely to want treatment stopped, but both groups wanted treatment stopped.).

126. Lawrence L. Heintz, *Legislative Hazard: Keeping Patients Living, Against Their Wills,* 14 J. MED. ETHICS 82 (1988); Alan E. Lazaroff & William F. Orr, *Living Wills and Other Advance Directives,* 2:4 CLINICS IN GERIATRIC MED. 521 (1986).

127. L. Emanuel, *supra* note 112; *see* Henderson, *supra* note 90.

at death.[128] More recently, planners have been encouraging clients to use durable powers of attorney limited to health care.[129] These have the advantage of covering any possible situation, not just those situations that may be covered by living wills. But some courts may not be willing to abide by the decision of an agent to withhold treatment without good evidence that such a treatment option would have been preferred by the patient. So cautious planners advise their clients to have both living wills and medical durable powers of attorney.[130]

Other sorts of advance medical directives may combine the proxy designation of the power of attorney with the treatment wishes of the living will. For example, one model medical directive contains "an instructional section, a durable power of attorney section, a values statement section, and an organ donation section in addition to the illness scenarios section."[131] Such a directive serves the functions of both living wills and durable powers of attorney.

Medical directives may specify how the agent's medical discretion should be exercised. In Illinois, patients usually choose the option that allows the withdrawal of treatment.[132] This is not surprising. Medical durable powers and medical directives have two main goals: (1) to reduce litigation, confusion, and pain by designating a decision-maker; and (2) to facilitate the withdrawal of treatment when the patient can no longer speak and would probably want it withdrawn.

V

ECONOMIC EFFICIENCY

Thus far I have examined the default rule of life, assuming that an individual has the right to control his medical treatment and that medical treatment should be based on the actual or probable consent of the patient. This is the prevailing principle that is professed (but not always followed) by the medical profession and the courts. It is also the principle that is most consistent with liberalism, libertarianism, and the liberal democracratic form of government that we have in the United States. It is not necessarily the result that would obtain under philosophies that are more morally deterministic or paternalistic.

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128. According to Justice O'Connor in *Cruzan*, "All 50 states and the District of Columbia have general durable power of attorney statutes." The statutes are cited there. Cruzan v. Missouri Dept. of Health, 497 U.S. 261, 290 n.3 (O'Connor, J., concurring).

129. Cohen-Mansfield et al., *supra* note 83, at 1174 (discussing study of use of medical powers; most patients chose their closest relative); Mary Kane Goldstein et al., *Durable Power Of Attorney For Health Care: Are We Ready For It?*, 155 WESTERN J. MED. 263 (1991) (study of durable power of attorneys in Veterans Affairs hospitals).

130. In 1990, 19 states (and the District of Columbia) had laws providing for durable power of attorney for health care. National Legal Center Staff, *supra* note 113, at 341. According to the *Cruzan* decision, in 1990 at least 13 states (and D.C.) had "durable power of attorney statutes expressly authorizing the appointment of proxies for making health care decisions." *See Cruzan*, 497 U.S. at 290 n.2 (O'Connor, J., concurring). In addition, in 1990 13 states "ha[d] living will statutes authorizing the appointment of healthcare proxies." *Id.* at 291 n.4.

131. *See* Emanuel, *supra* note 112; Emanuel & Emanuel, *supra* note 112.

132. *See supra* notes 83-86, 90, 109 and accompanying text.

In this part, I examine the results that would obtain under various strains of law and economics. Actually, from my discussions with law and ecomomics scholars, their approaches would be very similar to the analysis I have already engaged in. First, some assume that efficiency concerns come into play only after basic property and autonomy rights are established. The right to control one's body would be a prior right established by a positive legal system or recognized as a natural right. Law and ecomomics would then come into play only to analyze how the right to control treatment could be most efficiently carried out.

A second law and economics approach would establish the right to physical autonomy as an efficient legal rule.[133] The default rule of death would then follow from the right to autonomy. Law and economics could be used to show that autonomy was efficient without assuming autonomy as a first principle. Particular default rules need not be open to challenge as inefficient so long as they follow from the autonomy right, which is efficient. This approach is in essence a form of rule-utilitarianism.

Most economists would take one of the two approaches already mentioned. Both approaches would more or less recapitulate the analysis in the last part. Economists would, however, be less interested in polls than in medical directives expected to be acted on. Economists are more interested in behavior with consequences than in nonbinding preferences.

The third approach of law and economics scholars would be to assess the default rule of life or death without the intervening individual right to control treatment. The default rule would be assessed according to its efficiency under wealth, welfare, or utility maximization. The rest of this part examines the default rule in end-of-life situations under this third approach, trying to derive the default rule directly from efficiency concerns. My analysis is complex enough that, although I sometimes distinguish between wealth, welfare, and utility maximization, I usually don't distinguish them as fully or carefully as I would in a much longer treatment.

A. Wealth Maximization

1. *Allowing Unproductive People To Die*

Conventional (neoclassical) law and economics treats wealth maximization as the main goal of legal rules.[134] Usually distributive issues are ignored, as long as the pie grows larger.[135] In medicine, however, even taking economics

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133. *See, e.g.*, Lloyd Cohen, *A Justification of Social Wealth Maximization as a Rights-Based Ethical Theory*, 10 HARV. J.L. & PUB. POL'Y 411 (1987).

134. *See, e.g.*, RICHARD A. POSNER, THE ECONOMICS OF JUSTICE (1982); Richard A. Posner, *Utilitarianism, Economics, and Legal Theory*, 8 J. LEGAL STUD. 103 (1979); Gary Lawson, *Efficiency and Individualism*, 42 DUKE L.J. 53 (1992).

135. Richard W. Wright, *The Efficiency Theory of Causation and Responsibility: Unscientific Formalism and False Semantics*, 63 CHI.-KENT L. REV. 562, 563 (1987). *See also* Ronald Dworkin, *Why Efficiency?*, 8 HOFSTRA L. REV. 563 (1984).

explicitly into account is often rejected. As one panel report concluded: "There is currently no policy available on the national, local, or institutional levels that would ethically justify the use of economic considerations in decisions concerning life-sustaining treatment."[136] The same report goes on "to shun invidious comparisons of the economic value of various individuals to society, and to refuse to abandon patients and hasten death to save money."[137]

Only rarely do end-of-life cases treat wealth explicitly. When they do, it's usually to point out that allowing the patient to die will not cause minors or dependents to suffer materially.[138] Even in these cases, the issue is less whether wealth might be increased by keeping someone alive than whether particular children might suffer a loss (even if that loss would be offset by an equal gain to someone else). The class of cases where wealth seems to come into play are not the usual end-of-life situations, but blood transfusion cases. There parents of minor children are sometimes denied the right to refuse transfusions in life-threatening situations in small part because of financial concerns for children.[139]

Let's face it. As devastating as death is to the family of a terminally ill patient, an earlier death typically saves money. Medical care is extraordinarily expensive—currently about 13% of Gross National Product and growing. Yet 30% of Medicare funds are spent on the last year of life.[140] One recent study found that patients who were admitted with DNR orders incurred $10,631 in hospital costs, while those who received DNR orders while in the hospital incurred $73,055 in hospital costs.[141]

Occasionally, commentators express concerns about the resources spent on the elderly or terminally ill. Indeed, the British view embraces the rationing[142] of care explicitly:

> Resources provided to look after old people must necessarily be subtracted from those available for other, still more important dependent group, the children, with potentially disastrous results in underfunding of social support and education. . . . Many old people do not wish for further longevity after they have become too disabled to be of service to their families, and would prefer to see limited resources being used for the young.[143]

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136. HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 119 (1987).

137. *Id.* at 120.

138. *See, e.g.*, Foody v. Manchester Memorial Hospital, 482 A.2d 713 (Conn. Super. Ct. 1984); *In re* Conroy, 486 A.2d 1209 (N.J. 1985).

139. *See* Karnezis, *supra* note 16, § 4 at 80.

140. *Demanding Death With Dignity,* AMERICAN DEMOGRAPHICS 14 (Nov. 1991).

141. Alfred Maksoud et al., *Do Not Resuscitate Orders and the Cost of Death*, 153 ARCHIV. INTERN. MED. 1249 (1993).

142. *See, e.g.,* MARTIN A. STROSBERG, I. ALAN FEIN & JAMES D. CARROLL, RATIONING OF MEDICAL CARE FOR THE CRITICALLY ILL (1989); RUTH MACKLIN, MORTAL CHOICES 149-64 (1987).

143. Bliss, *supra* note 26, at 117.

Rationing has had less sympathetic treatment in the United States.[144] Polls suggest that many people (though not a majority) think that too much money is spent on the terminally ill.

Table 43
People Divided on Whether Too Much is Spent on the Terminally Ill

As far as you know, thinking not about what you may spend personally but on the total amount of money being spent on . . . treating patients who are terminally ill . . . in the United States, would you say this amount is too high, too low, or about right?

Too high	33%
Too low	20
About right	37
No response	10

BY: LOUIS HARRIS AND ASSOCIATES FOR HARVARD COMMUNITY HEALTH PLAN
SOURCE: COMPARING HEALTH SYSTEMS, 1990

Table 54
Opposition to Expensive Life Support

Where a patient is very ill and his doctor says he has no hope of recovery, do you think that patient's family should have the right to demand that he be kept alive by a very expensive life-support system?

Yes, should have	33%
No, should not have	63
Not sure	4

BY: LOUIS HARRIS AND ASSOCIATES FOR THE LORAN COMMISSION
SOURCE: MAKING DIFFICULT HEALTH CARE DECISIONS, 1987

It is interesting that in Table 54 people were opposed to the *right* of the family to demand expensive life support. I would expect that, if the words "very expensive" were omitted, people would be more willing to express support for family rights. Nonetheless, a legal rule that made death easier to achieve would save some of these funds.

And what does anyone get from the expenditure of these funds on the comatose or semicomatose terminally ill? The terminally ill themselves don't benefit from this money, because an overwhelming majority of people would not want to be kept alive if they became terminally ill. Their pain is prolonged against their probable wishes. Society generally doesn't benefit economically

144. Margaret P. Battin, *Age Rationing and the Just Distribution of Health Care: Is There a Duty to Die?*, 97 ETHICS 317 (1987); Howard Eglit, *Health Care Allocation for the Elderly: Age Discrimination by Another Name?*, 26 HOUS. L. REV. 813 (1989); 1 William B. Schwartz, *The Inevitable Failure of Current Cost-Containment Strategies*, 257 JAMA 220 (1987); Lester Carl Thurow, *Learning to Say "No,"* 311 NEW ENG. J. MED. 1569 (1984); Victor R. Fuchs, *The "Rationing" of Medical Care*, 311 NEW ENG. J. MED. 1572 (1984).

because the unconscious terminally ill seldom recover enough to do valuable work.

I'm not arguing that people have an obligation to commit suicide when they can no longer do useful work. Indeed, the idea that one person must die when society as a whole would economically benefit is a classic, if extreme, defect of viewing wealth maximization as a surrogate for welfare maximization. My point here is that honoring an unproductive person's wish to die would be wealth maximizing. One medical text states the problem, albeit imprecisely in terms of discrimination:

> Assessments of quality of life are sometimes based on economic value to society, social worth, or comparisons with other patients. Because the elderly have less income, less economic productivity, and higher medical costs than other groups, such considerations may lead to bias and discrimination against the elderly. Therefore, such considerations are not appropriate in making bedside medical decisions.[145]

If one had a rule that economically unproductive people must be killed—as part of Hitler's euthanasia program terminally ill Germans and other "useless eaters" were killed[146]—there would be substantial resources spent on avoidance. Thus some of the gains that a Nazi planner could hope to achieve by killing the unproductive would be dissipated by the extraordinary lengths that individuals and their families would take to avoid the harshness of such a rule.

But in our case of desperate end-of-life situations, avoidance costs should not be a significant problem. All that a person would have to do in order to avoid a new default rule of death would be to leave a medical directive mandating that heroic efforts be made to save one's life. The information cost of making an advance directive is currently high enough that most people who want living wills don't have them,[147] but the costs are far from prohibitive. Anyone who feels strongly may opt out of the default rule by making an advance directive mandating aggressive treatment. They need not go into hiding from the government.

In the end, wealth maximization would lead to a much broader use of treatment withdrawals than our present default rule of life or my suggested default rule of death. But it would allow too much. It would allow withdrawals of treatment from anyone economically unproductive—whether they were terminally ill or not, whether they would have probably preferred withdrawal or not.

As I mentioned earlier, most economists believe that some rights are economically wealth maximizing. This would complicate the analysis, but it

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145. Bernard Lo, *Quality of Life Judgments in the Care of the Elderly*, in MEDICAL ETHICS, *supra* note 7, at 141.

146. *See* RICHARD BREITMAN, THE ARCHITECT OF GENOCIDE: HIMMLER AND THE FINAL SOLUTION 89-91 (1991).

147. *Compare* Table 68 in the Appendix *with* Gallup Poll, GALLUP POLL MONTHLY 56 (Jan. 1991) (1990 poll) (80% don't have living wills; 75% of them want one).

would push it closer to my analysis in the section on what people want. If you actually had to buy out someone's life, in the case of an economically unproductive but otherwise quite happy retiree, no compensation is realistic. Your own value on your life on the day of retirement is quite high, perhaps approaching infinity. But as one lapses into semi-consciousness in a terminal illness, the value becomes much less and may even be negative. You might even be happy to pay someone to end your life.

Whether you would have to judge wealth-maximization by the ability to buy out the person to die is unclear. If simply killing someone who was a serious drain on resources would make the world richer, wouldn't that promote economic efficiency? In his defense of economic efficiency against utilitarianism,[148] Richard Posner argued that utilitarianism is subject to a criticism of moral monstrousness for the idea that killing a bad person would make the world better and increase general utility. But when Posner came to those people who are unproductive, with his usual candor he seemed to slouch toward the same morally offensive position:

> A less welcome implication of the wealth-maximization approach is that people who are very poor—not those who merely lack ready cash, but those who have insufficient earning power to be able to cover the expenses of a minimum decent standard of living—count only if they are part of the utility function of someone who has wealth. . . . If he happens to be born feeble-minded and his net social product is negative, he would have no right to the means of support though there was nothing blameworthy in his inability to support himself. This result grates on modern sensibilities yet I see no escape from it that is consistent with *any* of the major ethical systems.[149]

Posner discussed the status of the unborn by asking "whether additional population would be economically self-supporting."[150] This suggests that society would be richer if unproductive people were dead. This problem has led Posner more recently to embrace rights-based arguments as ultimate guides for legal rules, perhaps relegating wealth maximization itself to a secondary principle in extreme situations.[151] Yet even if Posner may have altered his normative views on wealth maximization, his earlier comments are a revealing basis for understanding how wealth maximization would treat the permanently unproductive.

I suppose that those who favor this form of efficiency would come up with some sort of clever rights-based argument as to why respecting people's wishes for life would increase the total pie even when the individuals are unproductive and no individual would receive pleasure from paying for the total costs of care. But I'll leave such an argument for others. If the rights of the unproductive can indeed be squeezed into a wealth-maximizing principle, then the analysis should

148. Richard A. Posner, *Utilitarianism, Economics, and Legal Theory*, 8 J. LEGAL STUD. 103 (1979).
149. *Id.* at 126.
150. *Id.*
151. RICHARD A. POSNER, THE PROBLEMS OF JURISPRUDENCE 376-80, 387 (1990).

track my previous analysis of what people want. In other words, if it's economically efficient to select a default rule that people want, then we should look to polls and experience with advance directives.

Simple wealth maximization would seem to support a rule favoring death in almost all situations involving the terminally ill. For my purposes, it suffices that wealth-maximization efficiency analysis would support a decision rule favoring withdrawals of treatment at least as broad as the one that I am advocating on other principles. Because I don't equate wealth maximization with welfare maximization, I need not endorse wealth-maximizing treatment withdrawals beyond those that coincide with the probable wishes of the patient.

2. *Penalty Default Rules* Ian Ayres and Robert Gertner have argued that the efficient default rule is sometimes the one that people would not have chosen. Certainly, this is true. Indeed, in the last section I recognized the morally monstrous argument that killing the unproductive might be economically efficient. Certainly, it wouldn't be what people would intend for themselves.

But Ayres and Gertner are making a more genteel argument. They introduce the idea of penalty defaults:

> Penalty defaults are designed to give at least one party to the contract an incentive to choose affirmatively the contract provision they prefer. In contrast to the perceived wisdom, penalty defaults are purposefully set at what the parties would not want—in order to encourage the parties to reveal information to each other or to third parties . . . .[152]

Although there are some significant differences between contracting and patient wishes for treatment,[153] there are enough similarities to warrant my examining whether the medical default rule is an efficient penalty rule. Ayres and Gertner define penalty rules sufficiently broadly that any rule that works against a party's desires becomes a penalty rule for that party. Thus any rule that punishes contracting parties is a penalty rule, whether it's a good rule or a bad rule, whether it's efficient or not.

There are several ways to apply Ayres and Gertner's analysis to end-of-life decisions. I will briefly explore the four most likely approaches. First, if you view the treatment contract between the doctor and the patient as arising while the patient is incompetent, there can be no economic justification for punishing the incompetent for not disclosing his treatment choices. Because he can't contract around them at that late date, a contract should be implied on terms that he would agree to if competent.

Second, one might consider Ayres and Gertner's rules for repeat players (who are a type of expert). They argue that sometimes one party will be more likely to be informed about the default rule and the contingencies that might

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152. Ayres & Gertner, *supra* note 63, at 91.

153. Of course, medical treatment is typically provided under a contract. But in many cases, the question is akin to whether there is a contract to treat or whether the quantity of treatment is specified.

arise:

> In some situations it is reasonable to expect one party to the contract to be systematically informed about the default rule and the probability of the relevant contingency arising. If one side is repeatedly in the relevant contractual setting while the other side rarely is, it is a sensible presumption that the former is better informed than the latter.[154]

They contend that repeat players, such as real estate agents,[155] should be penalized by the default rule so as to give them the incentive to bargain about contingencies that they can foresee. Doctors and hospitals, like real estate agents, are repeat players with a much greater knowledge of the default rule and the contingencies that might arise. This would suggest that, if anyone's preferred default rule should be chosen, it should be the patient's, not the hospital's.

Third, one might view end-of-life situations as questions about the "quantity" of medical care to be given—or perhaps about whether a contract for further treatment exists between the patient and the doctor or hospital. Under this characterization, Ayres and Gertner would apparently favor a penalty rule that denied a contract altogether, returning the patient to the *ex ante* status of no contract.[156] The problem with this status is that incompetent terminally ill patients can no longer negotiate their own contracts and they usually need at least painkillers. Thus we might want to imply a new contract for treatment; but again that contract should be implied on terms that the now incompetent patient would choose.

Fourth, one might view the default rule in end-of-life decisions as an inefficient penalty default rule. We know that most people want living wills and would prefer not to be kept alive if unconscious or dying with great pain.[157] We also know that most people have not left advance directives[158] and that those who have left living wills may not have executed broad enough ones to cover most of the relevant situations.[159] What could be the economic reason for this? The most likely explanation is that the information costs for patients are so high that they outweigh the expected benefits. This should make the penalty default rule inefficient under Ayres and Gertner's analysis.

There are two additional considerations that bear mentioning. Ayres and Gertner are fuzzy about what they mean by efficiency, but it appears that for them efficiency is wealth maximization. If so, then the odd problem of the negative productivity of permanently dependent people might render irrelevant what parties might agree to in a contract. In other words, this penalty rule

154. Ayres & Gertner, *supra* note 63, at 98.
155. *Id.* at 98-99.
156. *Id.* at 95-97.
157. *See supra* parts IV.A and IV.B.1.
158. *See supra* part IV.B.1.
159. *See supra* part IV.B.2.

analysis may be beside the point if (as I argued in the previous section) most contracts keeping the dependent alive would be economically inefficient.

In addition, Ayres and Gertner seem to dichotomize the choice of rules such that one can't achieve the benefits of disclosure without punishing someone. This isn't necessarily true. Especially where (as in health care) one party is not usually trying to take advantage of the other, there may be ways to encourage disclosure and planning without resorting to penalty rules in the event that the parties don't plan. As in legal ethics, we need not combine mandatory and aspirational standards. As I argued elsewhere regarding will formalities, there are ways to encourage compliance without punishing those who don't comply.[160] In health care, the federal government, the states, and many hospitals are doing just what I have recommended for wills. Under the Patient Self-Determination Act,[161] hospitals are required to discuss advance directives with their patients. Even stronger hospital policies have the potential for closing the gap without punishing those who didn't plan ahead. In some cases, we are literally *torturing* patients because they didn't plan for incompetence. That gives new meaning to the term *penalty rule.*

B. Utility, Happiness, or Welfare Maximization

Some economic theories are based on happiness, utility, or welfare maximization.[162] Although almost everyone agrees that there is more to happiness than money, economists are split on the wisdom of opening up the discipline to psychological and preference issues not usually cognizable in money. Robert Ellickson, for example, argues that the wealth-maximizing model of human behavior is not rich enough to explain the world.[163] Richard Posner, on the other hand, argues:

> [I]t would be a mistake to abandon the economic model—the most fruitful in the history of the social sciences—prematurely in favor of alternative models with an inferior track record. Professor Ellickson doesn't want to abandon the economic model but to improve it, but too many bells and whistles will stop the analytic engine in its tracks.[164]

The feature of welfare or utility analysis that makes it so difficult to use to model human behavior is that (as almost all economic theorists agree)

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160. James Lindgren, *Abolishing the Attestation Requirement for Wills,* 68 N.C.L. REV. 541, 546-47, 569-72 (1990).

161. Omnibus Budget Reconciliation Act of 1990, §§ 4206 & 4751, Pub. L. No. 101-508 (1990); Hudson, *supra* note 115; McCloskey, *supra* note 115.

162. I am particularly indebted in this section to Gary Lawson's and Herbert Hovenkamp's conflicting analyses of welfare maximization. *See* Herbert Hovenkamp, *The First Great Law & Economics Movement,* 42 STAN. L. REV. 993, 1031-58 (1990); Lawson, *supra* note 134.

163. Robert C. Ellickson, *Bringing Culture and Human Frailty to Rational Actors: A Critique of Classical Law and Economics,* 65 CHI.-KENT L. REV. 23 (1989).

164. Richard A. Posner, *The Future of Law and Economics: A Comment on Ellickson,* 65 CHI.-KENT L. REV. 57 (1989).

interpersonal comparisons of utility are impossible.[165] How much pleasure one receives from a particular activity is not measurable and may not even be conceivable.[166] As Lionel Rollins put it, "There is no means of testing the magnitude of A's satisfaction as compared with B."[167] These contentions lead to three possible ways to analyze end-of-life decisions as welfare maximization.

1. *The Skeptical Approach: No Interpersonal Comparisons of Utility.* First, one can take the approach of the most disciplined and skeptical economic theorists, the ordinalists.[168] Individuals may be able to rank order their own preferences for themselves. Yet because there is no way to measure welfare or to aggregate welfare on any sort of scale, one can't say that one approach or another will promote aggregate welfare. Attempts to achieve either Pareto or Kaldor-Hicks efficiency must of necessity fail, because there is no way to aggregate the welfare of different people. Without a system that actually makes everyone better off by buying off those who believe themselves made worse off (so that their own happiness is increased by their own lights), no outcome can be determined to be efficient as welfare maximization.

This analysis suggests the unreality of welfare maximization in practice. First, no full compensation system is ever attempted. Second, all it takes is one fanatic who values another rule high enough to thwart the efficiency of any rule.

2. *The Modified Skeptical Approach: What Would a Person Prefer?* The other two approaches to welfare or utility maximization don't solve the problem raised by the skeptical approach. Indeed, strictly speaking, they are not approaches that ensure welfare maximization. Under the second approach, one could avoid the problem of interpersonal comparisons of utility by determining, not whether one rule was preferable to another in total welfare, but instead whether a randomly selected person would prefer one rule to another. For that hypothetical person, one rule would be preferable to another. This approach would not tell us which rule maximized welfare, but (assuming adequate information) it would tell us which approach would be preferred by most people. Under this approach to welfare assessment, death should be the default rule in most end-of-life situations, because (as directives and polls show) a randomly selected person would be likely to prefer that default rule.

The usual theoretical problem with the approach I have just used is the tyranny of the majority. Perhaps a randomly selected person would prefer to enslave the poorest 5% of the population. Such a rule wouldn't seem to reflect

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165. *See* Hovenkamp, *supra* note 162, at 1033-51; JACK HIRSHLEIFER, PRICE THEORY AND APPLICATIONS 59 (1976); Ian Shapiro, *Richard Posner's Praxis,* 48 OHIO ST. L.J. 999, 1005 (1988); Gary Lawson, *supra* note 134, at 12-20.

166. *See* Gary Lawson, *supra* note 134, at 60-64.

167. LORD ROLLINS, AN ESSAY ON THE NATURE AND SIGNIFICANCE OF ECONOMIC SCIENCE 139-41 (2d ed. 1935).

168. Hovenkamp, *supra* note 162, at 1033-34; Robert Cooter & Peter Rappoport, *Were the Ordinalists Wrong About Welfare Economics?,* 22 J. ECON. LIT. 507 (1984). *See* Paul A. Samuelson, *Consumption Theory in Terms of Revealed Preferences,* 15 ECONOMETRICA 242 (1948).

total utility or happiness maximization because the utility loss to slaves might outweigh the utility gains to the majority (and indeed there's no way to tell). Yet under a slavery regime, the problem is that the costs of the rule are being borne almost completely by persons who wouldn't choose that rule—the slaves. Here, on the other hand, the person to die would choose the rule for himself, so the tyranny of the majority problem is more theoretical than actual.

3. *Rough Welfare Maximization.* A third approach to welfare assessment is to reject the consensus economic approach as a form of extreme philosophical skepticism. Here we would assume that people think similarly and respond to different situations similarly.[169] Most people, for example, prefer a good job to a single good meal and seem to direct more effort trying to get a good job. Thus, even if one couldn't know absolutely what people would prefer or how deeply the majority or the minority would feel about various legal rules, we could observe what they say or do. In other words, we could adopt an external standard for assessing preferences.[170] In 1927, Irving Fisher suggested that with enough data we could get a rough sense of families' utility functions.[171] Because in end-of-life situations, the relevant people haven't expressed preferences, we would have to assume they approach the world in much the same way as those whose preferences we know.

This rough utilitarian approach would be vehemently opposed by most economists because it directly challenges the skeptical approach that interpersonal comparisons of utility are impossible. This rough approach would treat each person as trying to maximize his own utility and as knowing what would make him happy. People would tend to know whether keeping themselves alive would be a good thing or not. And family members would know what would make them happy. Then if one could combine the rough utilities for the family and the patient together, one could assess what course of action was better. Thus, one might be able to roughly maximize welfare under this approach by doing whatever those most likely to have strong feelings would prefer in a particular situation. But a full-fledged utility analysis would have to account for the gains or losses to third parties beyond the family, chiefly medical personnel and the general public.

In many of the actual cases, there is no knowledge by the unconscious patient of what choice was made; thus, any gains to the patient's happiness or utility must be in anticipation of having his wishes followed. The real gains and losses in happiness would seem to me to come to the family—primarily emotionally, but also materially to the extent that costs are saved. Where the family members

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169. Hovenkamp, *supra* note 162, at 1050; Wesley C. Mitchell, *Human Behavior and Economics: A Survey of the Literature,* 29 Q.J. ECON. 1, 7-8 (1914).

170. Hovenkamp, *supra* note 162, at 1051-56.

171. *See* Irving Fisher, *A Statistical Method for Measuring "Marginal Utility" and Testing the Justice of a Progressive Income Tax, in* ECONOMIC ESSAYS CONTRIBUTED IN HONOR OF JOHN BATES CLARK 157 (J. Hollander ed., 1927).

agree to withdraw treatment, then a default rule doing the same might serve a rough sense of welfare or utility maximization.

But where a patient would choose life, but a family would choose death (or vice versa), even this rough, bastardized utility analysis breaks down. To the extent that the patient is conscious when the choice is made, he may receive pleasure if his presumptive wishes are followed. But his family would be made unhappy. How does one weigh these relative concerns? If the patient is unconscious, however, probably following the family's wishes would promote welfare or utility.

4. *Summary* Under the skeptical approach currently accepted in welfare economics, strict utility or welfare calculus is impossible. We can't aggregate people's welfare in the way that we aggregate money because interpersonal comparisons of utility are impossible. Under this skeptical approach, no default rule is welfare maximizing. Under a more limited skeptical approach, the default rule should be whatever a randomly selected person would be likely to do. Here that would favor withdrawing treatment in the same situations as the "intent of the patient" approach. Under the rough utilitarian approach in which comparisons of utility are thought to be possible, however, where the family agrees with a patient's probable wish for being allowed to die, the efficient rule under utility maximization would be to allow death. But if the family favored treatment when an unconscious patient probably wouldn't, then the comparison becomes more difficult; perhaps the default rule under rough utility or welfare maximization would be life in this limited situation.

VI

ERROR FUNCTIONS

One standard idea in law and economics that finds its way into noneconomic discussions of end-of-life situations is an error function.[172] Justice Rehnquist in the *Cruzan* majority opinion discusses this idea in the context of the standard of proof:

> We think it self-evident that the interests at stake in the instant proceedings are more substantial, both on an individual and societal level, than those involved in a run-of-the-mine civil dispute. But not only does the standard of proof reflect the importance of a particular adjudication, it also serves as "a societal judgment about how the risk of error should be distributed between the litigants." The more stringent the burden of proof a party must bear, the more that party bears the risk of an erroneous decision. We believe that Missouri may permissibly place an

172. *See* RONALD J. ALLEN & RICHARD B. KUHNS, AN ANALYTICAL APPROACH TO EVIDENCE: TEXT, PROBLEMS, AND CASES 129-32 (1989); MICHAEL O. FINKELSTEIN, QUANTITATIVE METHODS IN LAW 59-104 (1978); V.C. Ball, *The Moment of Truth: Probability Theory and Standards of Proof*, 14 VAND. L. REV. 807 (1961); John Kaplan, *Decision Theory and the Factfinding Process*, 20 STAN. L. REV. 1065 (1968); Richard Lempert, *Modeling Relevance*, 75 MICH. L. REV. 1021 (1977); Kate Stith, *The Risk of Legal Error in Criminal Cases: Some Consequences of the Asymmetry in the Right to Appeal*, 57 U. CHI L. REV. 1 (1990).

> increased risk of an erroneous decision on those seeking to terminate an incompetent individual's life-sustaining treatment. An erroneous decision not to terminate results in a maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science, the discovery of new evidence regarding the patient's intent, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment, at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction.[173]

Justice Brennan counters:

> The majority claims that the allocation of the risk of error is justified because it is more important not to terminate life-support for someone who would wish it continued than to honor the wishes of someone who would not. An erroneous decision to terminate life-support is irrevocable, says the majority, while an erroneous decision not to terminate "results in a maintenance of the status quo." But, from the point of view of the patient, an erroneous decision in either direction is irrevocable. An erroneous decision to terminate artificial nutrition and hydration, to be sure, will lead to failure of that last remnant of physiological life, the brain stem, and result in complete brain death. An erroneous decision not to terminate life-support, however, robs a patient of the very qualities protected by the right to avoid unwanted medical treatment. His own degraded existence is perpetuated; his family's suffering is protracted; the memory he leaves behind becomes more and more distorted.[174]

Brennan goes on:

> The majority's definition of the "status quo," of course, begs the question. Artificial delivery of nutrition and hydration represents the "status quo" only if the State has chosen to permit doctors and hospitals to keep a patient on life-support systems over the protests of his family or guardian. The "status quo" absent that state interference would be the natural result of his accident or illness (and the family's decision). The majority's definition of status quo, however, is "to a large extent a predictable, yet accidental confluence of technology, psyche, and inertia. The general citizenry . . . never said that it favored the creation of coma wards where permanently unconscious patients would be tended for years and years. Nor did the populace as a whole authorize the preeminence of doctors over families in making treatment decisions for incompetent patients."[175]

The idea behind an error function is that one should not look simply at the likelihood of a false positive or a false negative, but at the cost or disutility of each false outcome.[176] When the cost of one type of error is much higher than the other type of error, that should lower your willingness to run that risk.

But are the costs of a wrongful termination really worse than a wrongful prolongation of life? First, an early termination should save money; prolonga-

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173. Cruzan v. Missouri Dept. of Health, 497 U.S. 261, 283 (1990) (citations omitted).

174. *Id.* at 320 (Brennan, J., dissenting).

175. *Id.* at 268 n.17 (citing Nancy Rhoden, *Litigating Life and Death,* 102 HARV. L. REV. 375, 433-434 (1988)).

176. RONALD J. ALLEN & RICHARD B. KUHNS, AN ANALYTICAL APPROACH TO EVIDENCE: TEXT, PROBLEMS, AND CASES 129-32 (1989); John Kaplan, *Decision Theory and the Factfinding Process,* 20 STAN. L. REV. 1065 (1968).

tion, on the other hand, should cost money. So other things being equal, the economic cost of wrongful treatment is higher than wrongful withdrawal.

Second, the primary risks of wrongful death are an unwanted loss of life (which may be sacred[177] in a way that would prevent life-taking), a possibility of misdiagnosis, a possibility of medical advances in treatment, and a possibility that more might be found out about the patient's wishes for treatment. Yet all of these risks are knowable to patients themselves. How to weigh these risks against the risks on the other side—the expense, loss of dignity, loss of reputation and affection, pain, suffering, family suffering, and other drawbacks of treatment—is unknowable by anyone other than an individual. Doctors can provide estimates of some risks, but how to put them together in a single preference for or against treatment is something that only a patient can do. If patients have put these risks together and expressed a preference, it should be followed because the decision already reflects the error function. If when they answer polls and write advance directives people choose death rather than life in certain situations, then death should be the default rule because their preference already incorporates the possibility of error. In other words, an error function may be highly relevant to these decisions, but the only way to incorporate it into the analysis is to look at the preferences of people who might be aware of the risks of error.

VII

LETTING THE FAMILY DECIDE

The trend in the scholarly commentary is away from conclusions about the right answer in end-of-life situations and toward a model that designates who should choose. Behind the decision over who chooses is a practical advantage in gap-filling and a sense that someone who understands the situation as it has developed can make more intelligent choices. Further, some conceive the family rather than the individual as the relevant decisionmaking unit.

My analysis might add two reasons to this list. First, as discussed above, the surviving family has the biggest stake in the decision over a dying, unconscious patient. Whatever pain or welfare will be enhanced by a particular decision will be borne particularly by the family. Thus a welfare-maximizing economic planner might get a rough sense of welfare by looking at the choices of family members.

Second and more important, individuals prefer family involvement in the decision to withhold treatment. Many of the polls showing support for the right to withdraw treatment assume family involvement, and families more than other groups are favored for making these treatment decisions. What makes things ambiguous is that there is more support for the family and doctors deciding

177. "In the rush to acknowledge the quality of life, the sanctity of life must not be discarded." P.V. Caralis, *Withdrawal and Withholding of Life-Supporting Food and Fluids: One State's Struggle*, 77 J. FLA. MED. ASS'N 821 (1990).

together than for the families alone. The courts and hospital administration are little trusted.

Table 39
Preference for Family Decisions

If you were hospitalized in an unconscious state with a terminal illness, how confident are you that your wishes about continuing or stopping life-sustaining treatment would be followed by the [*courts/doctors/family]*? Are you very confident, somewhat confident, not very confident, or not confident at all that they would follow your wishes?

	Courts	Doctors	Family
Very confident	7 %	26%	51%
Somewhat confident	28	31	31
Not very confident	21	15	8
Not confident at all	30	16	6
Don't know	14	11	5

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 51
Preference for Family and Doctor Decisions

Let's take the case of a terminally ill patient who is unconscious and has not made his or her wishes known in advance. Who, if anyone, do you think should be allowed to make the decision to withdraw life-sustaining treatment? Should it be . . . the patient's family alone, or the patient's family and his or her doctors, or the patient's doctors alone, or the hospital, or the courts, or should it be that nobody should be allowed to make this decision?

Family alone	30%
Family and doctors	53
Patient's doctors alone	3
Hospital	0
Courts	3
Nobody should be allowed to make this decision	8
Don't know	3

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 52
Preference for Family and Doctor Decisions

In the event that a terminally ill patient cannot decide for himself or herself, do you think it would be best to leave the decision about ending the patient's life to:. . .

The family and its doctor	80%
Laws passed by legislators	2
The courts	7
Not sure	11

BY: YANKELOVICH CLANCY SHULMAN
SPONSOR: Time, Cable News Network
SOURCE: TIME/C.N.N./YANKELOVICH CLANCY SHULMAN, 1990

Because most patients want their families to decide when they can't, and most choose family members as proxies, families should play the major role in choosing the treatment for incompetent patients. But at least as strong as patient preferences for family decisionmaking are patient preferences for death. Families should be encouraged to choose what patients want. In end-of-life situations, doctors should make families aware of probable patient preferences for death.

VIII

CONCLUSION: WHEN THE DEFAULT RULE SWITCHES FROM LIFE TO DEATH

> *Anti-individualistic, the Fascist conception of life stresses the importance of the State and accepts the individual only in so far as his interests coincide with those of the State . . . . Liberalism denied the State in the name of the individual; Fascism reasserts the rights of the State as expressing the real essence of the individual.*
>
> — Benito Mussolini[178]

Like the Fascist state advanced by Mussolini, the states of New York and Missouri have put the rights of the state above the rights of the individual. Other states and much of the medical profession also start with a default rule of life in desperate end-of-life situations. Under the usual standards for default rules in law and economics, life as the default rule here makes no sense. Usually, a default rule is the one that the party would have chosen if she could speak. In end-of-life situations it usually isn't. Or a default rule promotes efficiency in the form of wealth maximization. Most assuredly, it doesn't here. Or it promotes efficiency in the form of happiness, welfare, or general utility. Either welfare analysis is theoretically impossible here or, if it isn't, a rough

178. BENITO MUSSOLINI, FASCISM: DOCTRINES AND INSTITUTIONS 10-11 (1935).

utilitarian approach would lead to a default rule of death (at least where the family agrees). Under all three ways of analyzing default rules, the current default rule in *Cruzan* and *O'Connor* fails.

If the default rule for end-of-life situations should be death and the default rule for normal medical situations should be life, where do you draw the line? When should the default rule switch from life to death? The existing rule favoring life at least has simplicity and consistency to commend it. But because most cases eventually lead to decisions to withdraw treatment, the existing rule is inconsistent in practice.

This line-drawing problem is enormously difficult, but it strangely adds little in the way of theoretical complexity because the line I propose using is exactly the same as the one that people want. The default rule should switch wherever patient preferences switch. Thus, one must determine when most people would prefer to have at least some treatments withdrawn. According to national public opinion polls, it appears that there are at least eight such overlapping situations:

(1) patients on life support who have no hope of recovery;[179]

(2) patients in a coma with no brain activity being kept alive by a feeding tube;[180]

(3) patients who are terminally ill or in irreversible coma, supported by life support systems, including food and water;[181]

(4) patients with an illness that makes them totally dependent on a family member or other person for all of their care (a situation in which they would not want their doctors "to do everything possible to save" life);[182]

(5) patients with a disease with no hope of improvement suffering a great deal of physical pain;[183]

(6) patients in a coma with no hope of recovery but no pain;[184]

(7) hopelessly ill or comatose patients on life support if their families request the withdrawal of support;[185] and

(8) permanently unconscious patients receiving food and water.[186]

The study of medical directives and further polling of doctors, nursing home residents, the elderly, and retirees reveals more situations in which at least some treatments should be withheld:

(9) patients with a terminal illness which has progressed and caused their heart to stop beating;[187]

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179. *See* Table 1.
180. *See* Table 2.
181. *See* Table 3.
182. *See* Table 4 (subjects would not tell their doctors "to do everything possible to save" life). It would not be wise to read this study as expressing a desire to withdraw all treatment, simply as a desire to withdraw *some* treatments.
183. *See* Table 5.
184. *See* Table 6.
185. *See supra* part IV.A.1.
186. *See supra* part IV.A.1.
187. *See* Table 79.

(10) mentally incompetent patients with a terminal illness which has progressed and caused their heart to stop beating;[188]
(11) permanently unconscious patients in a persistent vegetative state unable to eat normally, needing artificial feedings;[189]
(12) nursing home patients, no matter what the level of cognitive functioning at time of treatment, needing resuscitation, amputation, or tube feeding (either temporary or permanent);[190]
(13) nursing home residents about to die of natural causes needing drugs, fluids, food by tubes, breathing machines, or heart massage;[191] and
(14) terminally ill retirees needing CPR, a respirator, a nasogastric feeding tube, or intravenous fluids.[192]

Among the only contrary situations are resuscitation and hospitalization for AIDS patients. AIDS patients, however, seem to prefer not to be ventilated or resuscitated if the disease has progressed to severe memory loss and severe pneumonia. For other terminal illnesses, early treatments seem to be desired, but more extreme treatments are increasingly not desired.[193]

How one should use all this information about patient preferences will depend on other views about decisionmaking for incompetent patients. Doctors advising a family can explain that most patients would want treatment withdrawn. This information might lessen anxiety and economic costs if the family ultimately chooses what most families choose, to let the patient die. Doctors can base their advice on the statistical preferences of patients, much as they now base advice on the statistical prognosis for various conditions. Families of patients in most end-of-life situations should be explicitly told, for example, that 73-85% of the adult population would prefer to have treatment withdrawn and that 86-93% of doctors would prefer no treatment for themselves. Because eventually most patients are allowed to die, making families aware of the preferences of most people should lessen anxiety and facilitate earlier resolution. Families who wish to follow the patient's wishes will have guidance and support.

As stated earlier, where families and patients disagree, the analysis becomes more complex. My analysis and the literature on patient preferences are inconclusive. Patients both want death and want their families to decide.

Further, I am talking here about *default* rules, rules that may be varied by expressed patient preferences. There rightly should be some concern about how far doctors and families could legally go, even if patients wanted it. Thus, you would want to ascertain whether you would withdraw life-preserving treatments if you had excellent evidence that a patient, currently silent, wanted them

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188. *See* Table 80.
189. *See* Table 81.
190. *See supra* part III. A. 1.
191. *See* Table 82 (68% of 75 nursing home residents in Pitt County, North Carolina, would not want treatment).
192. *See* Table 83.
193. *See id.*; Marion Davis, *A Prospective Study of Advance Directives for Life-Sustaining Care*, 324 NEW ENG. J. MED. 882 (1991) (directives executed by 126 nursing home residents).

withdrawn. If you are willing to go that far in stopping treatment and most patients would want you to do it, then do it (unless you have evidence of a contrary intent).

Medical care is supposed to be based on the informed consent of the patient. Unconsented treatment is supposed to be a battery. Yet under the influence of the *O'Connor* and *Cruzan* decisions, unconsented treatment has been made legally acceptable in a few jurisdictions. Some courts seem to be confused about what they're doing. They're willing to follow a patient's wishes when they're "clear and convincing," but ignore them if they aren't. Perhaps that would make sense if the default rule were set to reflect most people's wishes toward withdrawing life-sustaining treatment in desperate end-of-life situations. Then we would be saying: Unless we have proof that this terminally ill patient is different from other terminally ill patients, we will treat this patient as others would like to be treated and withdraw life support. But with life as the default rule, we are frustrating the intent of most patients subject to that rule.

Further, where does the state properly acquire the right to impose treatment on patients? Hospitals may treat unconscious emergency victims because they would want treatment; consent is implied. But a hospital or the state acts improperly when it imposes treatment without express or implied consent.

Before doctors began to understand the etiology of disease in the late 1800s—when the chief medical treatments were bloodletting, cathartics, and blistering—common law courts developed a workable system for initiating and terminating treatment, the consent of the patient.[194] Where it was difficult to know whether treatments would do any good, the wishes of the patient controlled. Ironically, the very proficiency of modern doctors and medical equipment has put us back in a situation much like that before the mid-1800s. Doctors can provide standard medical treatments to keep dying people alive, but it's unclear whether these treatments do any real good. Perhaps, like blistering, they do more harm than good. In this limbo, let patients decide. And where the patient would have chosen death rather than life, the default rule should be death.

194. Lori Andrews, *Taking Care of the Doctor-Patient Relationship*, AM. BAR FOUND. RES. J. 268-69 (1981).

APPENDIX

SELECTED STUDIES AND NATIONAL PUBLIC OPINION POLLS ON WITHDRAWING LIFE-SUSTAINING TREATMENT*

I

TREATMENT PREFERENCES

Table 1. If you, yourself, were on life support systems and there was no hope of recovering, would you like to remain on the life support system or would you like treatment withheld so that you could end your life?

Treatment Withheld	84%
Kept on Life Support	9
No opinion	7

BY: GALLUP ORGANIZATION
SOURCE: GALLUP POLL, 1990

Table 2. Suppose you were in a coma with no brain activity and were being kept alive by a feeding tube. Would you want your doctor to remove the feeding tube and let you die, or not?

Want removal of feeding tube	85%
Would not want tube removed	11
Don't know/No answer	4

BY: CBS NEWS/NEW YORK TIMES
SOURCE: CBS NEWS/NEW YORK TIMES, 1990

Table 3. If you, yourself, were terminally ill or in irreversible coma, would you want life support systems, including food and water, withdrawn or not?

Yes	73%
No	21
Unsure	7

BY: GALLUP ORGANIZATION
SPONSOR: American Medical Association
SOURCE: HEALTH CARE ISSUES, 1990

* Sincere thanks are owed to the staff of the Roper Center at the University of Connecticut for their kind assistance and for their database from which nearly all of the opinion polls were drawn. Section IV, "Toward Euthanasia," represents only a small fraction of the available polls on that issue and suicide. Poll questions asked of only a subgroup, such as those answering "yes" to another question, were excluded from this compilation. Only national polls are included, except for the studies in the last section.

Table 4. How about if you had an illness that made you totally dependent on a family member or other person for all of your care? (Repeat if necessary: Would you tell your doctor to do everything possible to save your life, or would you tell your doctor to stop treatment?)

Stop treatment	51%
Save life	31
It depends (volunteered)	7
Don't know	11

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1
SURVEY: 1990

Table 5. Now, I'm going to describe a few medical situations that sometimes happen, and for each one, please tell me what you would want your own doctor to do, if you could make the choice. If you had a disease with no hope of improvement and you were suffering a great deal of physical pain, would you tell your doctor to do everything possible to save your life, or would you tell your doctor to stop treatment so you could die?

Stop treatment	59%
Save life	28
It depends (vol.)	6
Don't know	7

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1, 1990

Table 6. Imagine you were in a coma with no hope of recovery, were suffering no pain, and had left no instructions to your family or closest friend stating your wishes. Would you want them to ask your doctor to withdraw life-sustaining treatment, or would you not?

Yes, I would	75%
No, I would not	17
Something else (vol.)	2
Don't know	6

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 7. How about if you had a disease with no hope of improvement that made it hard for you to function in your day-to-day activities? (Repeat if necessary: Would you tell your doctor to do everything possible to save your life, or would you tell your doctor to stop treatment?)

Stop treatment	44%
Save life	40
It depends (volunteered)	8
Don't know	8

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1, 1990

Table 8. If you, yourself, were on life support systems and there was no hope of recovering, would you like to remain on the life support system or would you like treatment withheld so that you could end your life?

	Kept on life support	Treatment withheld	No opinion
TOTAL:	9%	84%	7%
Age:			
18-29	11	85	4
30-49	8	84	8
50 or older	9	82	9
Does getting older bother you?:			
A great deal	17	70	14
Somewhat	9	87	5
Not at all	8	84	8
Fear of death:			
Yes, fear death	11	83	6
No, don't fear death	8	84	8
Thinking about death:			
Very often or somewhat often	7	85	8
Every now & again or almost never	9	83	7
Religion:			
Protestant	9	84	8
Catholic	8	85	7
Jew	9	91	0
None	10	80	11
Born-Again Christian:			
Yes, born-again	9	84	7
No, not born-again	8	85	7
Church/Synagogue Member:			
Yes, church/synagogue member	9	84	8
No, not c/s member	9	84	7

Table 8 (continued)

	Kept on life support	Treatment withheld	No opinion
Attended church in last 7 days:			
Yes, attended church	10	82	9
No, didn't attend church	8	85	6
Sex:			
Male	11	82	7
Female	7	85	8
Education:			
College Graduate	9	82	9
Some College	10	83	7
High-School Graduate	9	86	5
Less Than H-S Graduate	7	82	12
Education by Sex:			
College Male	13	79	8
College Female	6	86	8
Noncollege Male	9	85	6
Noncollege Female	8	85	7
Race:			
White	7	87	6
Black	19	64	17
Other	25	71	5
Region:			
East	14	78	8
Midwest	7	87	6
South	8	83	10
West	6	88	7
Income:			
$50,000 +	8	89	3
$30,000-49,900	10	86	5
$20,000-29,900	5	86	9
Under $20,000	11	83	7
Political Party:			
Republican	9	84	7
Democratic	11	82	7
Independent	7	86	8
Ideology:			
Liberal	8	86	6
Moderate	6	91	3
Conservative	9	84	7

BY: GALLUP ORGANIZATION
SOURCE: GALLUP POLL, 1990 (demographic data previously unpublished)

Table 9. What do you think your . . . father . . . would want his doctor to do in these same situations? If he had a disease with no hope of improvement and was suffering a great deal of physical pain, do you think he would want his own doctor to do everything possible to save his life, or would he want the doctor to stop treatment so he could die?

Save life	32%
Stop treatment	50
It depends (vol.)	2
Don't know	16

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1, 1990

Table 10. What do you think your . . . mother . . . would want her doctor to do in these same situations? If she had a disease with no hope of improvement and was suffering a great deal of physical pain, do you think she would want her own doctor to do everything possible to save her life, or would she want the doctor to stop treatment so she could die?

Save life	31%
Stop treatment	54
It depends (vol.)	2
Don't know	13

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1, 1990

Table 11. What if you had an illness with no hope of recovery and were suffering a great deal of physical pain. Do you think you would consider alternatives that would end your life, or would you probably not?

Yes, I would	52%
No, I would not	36
Something else (vol.)	1
Don't know	11

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 12. How about if . . . your father . . . had an illness that made him totally dependent on a family member or other person for all of his care? (Repeat if necessary: Do you think he would want his own doctor to do everything possible to save his life, or would he want the doctor to stop treatment?)

Save life	32%
Stop treatment	48
It depends (vol.)	2
Don't know	18

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1, 1990

Table 13. How about if . . . your mother . . . had an illness that made her totally dependent on a family member or other person for all of her care? (Repeat if necessary: Do you think she would want her own doctor to do everything possible to save her life, or would she want the doctor to stop treatment?)

Save life	33%
Stop treatment	49
It depends (vol.)	2
Don't know	16

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1, 1990

Table 14. How about if . . . your father . . . had a disease with no hope of improvement that made it hard to function in day-to-day activities? (Repeat if necessary: Do you think he would want his own doctor to do everything possible to save his life, or would he want the doctor to stop treatment?)

Save life	38%
Stop treatment	42
It depends (vol.)	2
Don't know	18

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1, 1990

Table 15. How about if . . . your mother . . . had a disease with no hope of improvement that made it hard to function in day-to-day activities? (Repeat if necessary: Do you think she would want her own doctor to do everything possible to save her life, or would she want the doctor to stop treatment?)

Save life	39%
Stop treatment	43
It depends (vol.)	2
Don't know	16

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1, 1990

II

FOLLOWING THE PATIENT'S TREATMENT CHOICE AND THE RIGHT TO DIE

Table 16. The New Jersey Supreme Court recently ruled that all life-sustaining medical treatment may be withheld or withdrawn from terminally ill patients, provided that is what the patients want or would want if they were able to express their wishes. Would you like to see such a ruling in the state where you live, or not?

Favor	81%
Oppose	13
No opinion	6

BY: GALLUP ORGANIZATION
SOURCE: GALLUP REPORT, 1985

Table 17. In 1985, the State Supreme Court in New Jersey ruled that life-sustaining medical treatment may be withheld or withdrawn from terminally ill patients, provided that is what the patients want or would want if they were able to express their wishes. Would you like to see such a ruling in your state, or not?

Yes	79%
No	15
Not sure	5
Refused	1

BY: LOS ANGELES TIMES
SOURCE: LOS ANGELES TIMES, 1989

Table 18. Would you favor or oppose withdrawing life support systems, including food and water, from hopelessly ill or irreversibly comatose patients if they or their families request it?

	1990	1986
Favor	78%	73%
Oppose	11	15
Not sure	11	12

BY: KANE, PARSONS AND ASSOCIATES (1986); GALLUP ORGANIZATION (1990)
SPONSOR: American Medical Association
SOURCE: HEALTH CARE ISSUES, 1990, 1986

Table 19. Do you think doctors should be allowed to withdraw life-sustaining treatment for a terminally ill patient who is . . . unconscious but has left written instructions in a "living will"?

Yes	81%
No	14
Not sure	5

BY: YANKELOVICH CLANCY SHULMAN
SPONSOR: Time, Cable News Network
SOURCE: TIME/C. N. N. /YANKELOVICH CLANCY SHULMAN, 1990

Table 20. Do you think doctors should be allowed to withdraw life-sustaining treatment for a terminally ill patient who is . . . conscious and requests it?

Yes	73%
No	19
Not sure	8

BY: YANKELOVICH CLANCY SHULMAN
SPONSOR: Time, Cable News Network
SOURCE: TIME/C. N. N. /YANKELOVICH CLANCY SHULMAN, 1990

Table 21. Recently there have been newspaper and television stories about the terminally ill and their right to have life-support systems disconnected. In your opinion, does a terminally ill person and/or one who is permanently bedridden and kept alive by medical machinery have the right to request to be allowed to die?

Absolutely yes, without question	58%
Yes, but only if medical opinions agree that the case is hopeless	22
Yes, but only if medical expenses are burdening the family	2
Yes, if tax dollars are being spent to keep the patient alive	1
No, because it is religiously and ethically wrong	3
No, because where there is life there is hope	4
Positively no, without exception	2
Don't know	5
No answer	2

BY: RESEARCH AND FORECASTS
SPONSOR: American Board of Family Practice
SOURCE: RIGHTS AND RESPONSIBILITIES: HEALTHCARE OPINIONS, 1984

Table 22. In some states, it's legal to stop medical treatment that is keeping a terminally ill patient alive, or never start the treatment in the first place, if that's what the patient wants. Do you approve or disapprove of laws that let patients decide about being kept alive through medical treatment?

Approve	79%
Disapprove	13
It depends (vol.)	5
Don't know	3

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1, 1990

Table 23. Do you think that the law should allow doctors to honor the written instructions of their patients, even if it means allowing them to die?

Yes, should allow	68%
No, should not allow	20
Not sure	11

BY: LOUIS HARRIS AND ASSOCIATES
SPONSOR: The President's Commission for The Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.
SOURCE: MAKING HEALTH CARE DECISIONS, 1982

Table 24. Which comes closer to your view? In all circumstances, doctors and nurses should do everything possible to save the life of a patient. Or, sometimes there are circumstances where a patient should be allowed to die.

Always save a life	15%
Sometimes let a patient die	73
It depends (vol.)	7
Don't know	5

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1, 1990

Table 25. Because of advances in medical technology, doctors are now able to keep people alive who otherwise might die. If patients ask doctors to stop keeping them alive, do you think doctors should do this, even if this means the patient will die, or do you think doctors should not do this?

Doctors should do	73%
Doctors should not do	19
Not sure	8

BY: NBC NEWS/WALL STREET JOURNAL
SOURCE: NBC NEWS/WALL STREET JOURNAL, 1988

Table 26. All doctors take an oath saying they will maintain, restore and prolong human life in their treatment of patients. It is now argued by some people that in many cases people with terminal diseases (those which can only end in death) have their lives prolonged unnecessarily, making them endure much pain and suffering for no real reason. Do you think a patient with a terminal disease ought to be able to tell his doctor to let him die rather than to extend his life when no cure is in sight, or do you think this is wrong?

	1981	1977	1973
Let die	78%	71%	62%
Wrong	19	18	28
Not sure	3	11	10

BY: LOUIS HARRIS & ASSOCIATES
SOURCE: HARRIS SURVEY, 1981, 1973

Table 27. Generally speaking, do you agree or disagree with the following statement: "Life sustaining medical treatment should be withheld or withdrawn from terminally-ill patients, provided that is what the patients want, or what the family wants if the patients are not able to express their wishes. " (If agree or disagree) Is that (agree/disagree) somewhat or (agree/disagree) strongly?

Agree strongly	65%
Agree somewhat	21
Disagree somewhat	4
Disagree strongly	5
Not sure	4
Refused	1

BY: LOS ANGELES TIMES
SOURCE: LOS ANGELES TIMES, 1989

Table 28. Let's take the case of a terminally ill person who is conscious and suffering a great deal of pain. If this person requests that his or her doctors withhold life-sustaining treatment, do you think the doctors should be required to do so, or allowed but not required to do so, or prohibited from withholding life-sustaining treatment?

Required to withhold	34%
Allowed to withhold but not required	46
Prohibited from withholding	9
Something else	3
Don't know	7

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 29. Let's take the case of a terminally ill patient who is unconscious and has left written instructions in a living will calling for doctors to withdraw life-sustaining treatment in this situation. Do you think the patient's doctors should be required to withdraw life-sustaining treatment, or allowed to withdraw life-sustaining treatment without being required to do so, or prohibited from withdrawing life-sustaining treatment?

Required to withdraw	41%
Allowed to withdraw but not required	46
Prohibited from withdrawing	6
Something else (vol.)	2
Don't know	5

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 30. Do you believe that your stated wishes (in your "living will") will be followed if the situation arises (concerning the use of life-sustaining treatment if you ever enter a coma from which doctors do not believe you can recover)?

Yes	85%
No	6
Unsure	9

BY: TARRANCE/S.R.I.
SPONSOR: American Medical Association
SOURCE: HEALTH CARE ISSUES, 1988

Table 31. Suppose a terminally ill person wants treatment withheld so that he or she may die. Please tell me whether or not you agree with each of the following statements. The patient has the right to stop treatment (ROTATED):

	Yes	No
If the doctor agrees:	75%	22%
If he or she is in great pain:	78	18
If his or her family agrees:	76	22
Under any circumstances:	59	38
Under no circumstances:	11	87

BY: GALLUP ORGANIZATION
SOURCE: GALLUP POLL, 1990

Table 32. Would you strongly favor, favor, oppose, or strongly oppose withdrawing life support systems including food and water from hopelessly ill or irreversibly comatose patients if they or their families request it?

Strongly favor	45%
Favor	31
Oppose	9
Strongly oppose	6
Don't know	10

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 33. Do you think that the law should allow doctors to honor the written instructions of their patients, who are very ill with no hope of recovery, even if it means allowing them to die?

Yes, should allow	84%
No, should not allow	13
Not sure	3

BY: LOUIS HARRIS AND ASSOCIATES
SPONSOR: The Loran Commission
SOURCE: MAKING DIFFICULT HEALTH CARE DECISIONS, 1987

Table 34. Do you favor or oppose the following? . . . A terminally ill patient's right to stop his/her own treatment

Favor	79%
Oppose	14
Don't know/No answer	7

BY: RESEARCH AND FORECASTS
SPONSOR: The Hearst Corporation
SOURCE: KNOWLEDGE OF HEALTH AND PHYSICAL WELL-BEING, 1985

Table 35. Assuming that a patient is judged mentally capable of understanding the terminal or permanent nature of his condition, if that patient's request to be allowed to die is denied by anybody, do you think. . .

The doctor should support the patient's request to die	31
The patient's civil rights are being denied if his request to die is not acted on	32
The hospital administrators should have no say in the matter	6
The court should be the final judge about a patient's request to die	7
The patient should never be allowed the choice to die	7
The hospital administrators should alone make the decision	1
Don't know	10
No answer	5

BY: RESEARCH AND FORECASTS
SPONSOR: American Board of Family Practice
SOURCE: RIGHTS AND RESPONSIBILITIES: HEALTHCARE OPINIONS, 1984

Table 36. Which of the following people do you think has the right and the responsibility to honor a terminally ill patient's request to be allowed to die?

The patient and family	54%
The patient and the doctor	37
The patient alone	39
Only the family and family doctor	21
Only complete agreement of the patients, the patient's doctor, the patient's family, the hospital medical staff, and the patient's religious leader	17
The family doctor and hospital medical staff	15
The hospital medical staff	7
The patient's religious leader	7
Don't know	2

BY: RESEARCH AND FORECASTS
SOURCE: RIGHTS AND RESPONSIBILITIES: HEALTHCARE OPINIONS, 1984

Table 37. Generally speaking, do you agree or disagree with the following statement: Life-sustaining medical treatment should be withheld or withdrawn from terminally-ill patients, provided that is what the patients want, or what the family wants if the patients are not able to express their wishes? (If agree or disagree) Is that (agree/disagree) somewhat or (agree/disagree) strongly?

Agree strongly	69%
Agree somewhat	20
Disagree somewhat	2
Disagree strongly	5
Not sure	3
Refused	1

BY: LOS ANGELES TIMES
SOURCE: LOS ANGELES TIMES, 1990

Table 38. Assume that the cancer has spread throughout the body. It is very likely that you will die regardless of what you do. There is a decision between aggressive therapy—which will probably make you feel sick and will probably not help your condition—and supportive therapy—which will not help your condition, but will allow you to be comfortable. Who do you think should make the decision between these two therapies—the doctor or you?

Doctor should make the decision	12%
I should make the decision	79
Should be joint decision (vol.)	8
Not sure	1

BY: LOUIS HARRIS AND ASSOCIATES
SPONSOR: The President's Commission for The Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.
SOURCE: MAKING HEALTH CARE DECISIONS, 1982

Table 39. If you were hospitalized in an unconscious state with a terminal illness, how confident are you that your wishes about continuing or stopping life-sustaining treatment would be followed by the *[courts/doctors/family]*? Are you very confident, somewhat confident, not very confident, or not confident at all that they would follow your wishes?

	Courts	Doctors	Family
Very confident	7 %	26%	51%
Somewhat confident	28	31	31
Not very confident	21	15	8
Not confident at all	30	16	6
Don't know	14	11	5

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 40. How much attention do you think doctors and nurses pay to instructions from patients about whether or not they want treatment to keep them alive? Do you think doctors and nurses pay a lot of attention, some attention, or very little attention to patients' instructions?

A lot of attention	20%
Some attention	37
Very little attention	26
No attention at all (vol.)	2
Don't know	15

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1, 1990

Table 41. (I am going to read some statements to you about current issues. Please indicate if you strongly agree, slightly agree, slightly disagree, or strongly disagree.) . . . A terminally ill person should have the right to refuse life prolonging medical treatment.

	1987	1986	1984
Strongly agree	78%	75%	77%
Slightly agree	16	17	15
Slightly disagree	2	4	2
Strongly disagree	2	2	4
No opinion/Not sure	1	3	2

BY: MARK CLEMENTS RESEARCH
SPONSOR: Glamour Magazine
SOURCE: WOMEN'S ATTITUDES, 1987, 1986, 1984
SURVEY POPULATION: Women aged 18-65

Table 42. (Now let me ask you about a number of issues here at home. For each, tell me if you favor or oppose it.) . . . A new law that would allow doctors to let a hopelessly ill patient die, if the patient has expressed a desire for this when fully competent

Favor	77%
Oppose	20
Not sure	3

BY: LOUIS HARRIS AND ASSOCIATES
SPONSOR: The Democratic Governors Association and Democrats for the 80's.
SOURCE: KEY ISSUES IN THE COUNTRY IN 1987, 1987

Table 43. As far as you know, thinking not about what you may spend personally but on the total amount of money being spent on . . . treating patients who are terminally ill . . . in the United States, would you say this amount is too high, too low, or about right?

Too high	33%
Too low	20
About right	37
No response	10

BY: LOUIS HARRIS AND ASSOCIATES
SPONSOR: Harvard Community Health Plan
SOURCE: COMPARING HEALTH SYSTEMS, 1990

III

TREATMENT WITH THE AGREEMENT OF OTHERS

Table 44. Suppose a patient is in a coma, doctors say brain activity has stopped and the patient is getting food and water through a feeding tube. Should a close family member have the right to tell the doctor to take away the feeding tube and let the person die, or not?

Allow feed tube removal	81%
Not allow	13
Don't know/No answer	6

BY: CBS NEWS/NEW YORK TIMES
SOURCE: CBS NEWS/NEW YORK TIMES, 1990

Table 45. If a person has an incurable disease and is very ill and unable to give his consent to have his life ended, do you think that a doctor should or should not be allowed to end his life provided the next of kin agree?

Should	66%
Should not	20
Don't know	14

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 46. In cases in which a coma patient is being kept alive only by a machine that supplies water and liquid food, do you think that the law should. . .

Require that the machine continue operating until the patient dies or recovers	7%
Allow the machine to be turned off only if the patient previously stated such a preference	26
Allow the family members to make the decision to turn off the machine	51
Allow doctors to make the decision to turn off the machine	9
Don't know	7
Refused	1

BY: I.C.R. SURVEY RESEARCH GROUP
SPONSOR: Maturity News Service
SOURCE: RIGHT TO DIE EXCEL STUDY, 1990

Table 47. If a patient with a terminal disease is unable to communicate and has not made his or her own wishes known in advance, should the closest family member be allowed to decide whether to continue medical treatment, or should a family member not be allowed to make this decision?

Allowed	71%
Not allowed	16
It depends (vol.)	5
Don't know	8

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1, 1990

Table 48. There have been cases where a patient is terminally ill, in a coma and not conscious, with no cure in sight. Do you think that the family of such a patient ought to be able to tell doctors to remove all life support services and let the patient die, or do you think this is wrong?

Ought to be allowed	66%
Think is wrong	19
Not sure	15

BY: LOUIS HARRIS AND ASSOCIATES
SOURCE: HARRIS SURVEY, 1977

Table 49. Do you think a family member should or should not be able to make the decision to terminate life support systems on a terminally ill patient who is in a coma?

Should be able to decide	68%
Should not be able to decide	15
Depends on circumstances (vol.)	13
Not sure	4

BY: HART AND TEETER RESEARCH COMPANIES
SPONSOR: NBC NEWS/WALL STREET JOURNAL
SOURCE: NBC NEWS/WALL STREET JOURNAL, 1990

Table 50. There have been cases where a patient is terminally ill, in a coma and not conscious, with no cure in sight. Do you think that the family of such a patient ought to be able to tell doctors to remove all life-support services and let the patient die, or do you think this is wrong?

Have right	73%
Wrong	23
Not sure	4

BY: LOUIS HARRIS & ASSOCIATES
SOURCE: HARRIS SURVEY, 1981

Table 51. Let's take the case of a terminally ill patient who is unconscious and has not made his or her wishes known in advance. Who, if anyone, do you think should be allowed to make the decision to withdraw life-sustaining treatment? Should it be . . . the patient's family alone, or the patient's family and his or her doctors, or the patient's doctors alone, or the hospital, or the courts, or should it be that nobody should be allowed to make this decision?

Family alone	30%
Family and doctors	53
Patient's doctors alone	3
Hospital	0
Courts	3
Nobody should be allowed to make this decision	8
Don't know	3

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 52. In the event that a terminally ill patient cannot decide for himself or herself, do you think it would be best to leave the decision about ending the patient's life to:. . .

The family and its doctor	80%
Laws passed by legislators	2
The courts	7
Not sure	11

BY: YANKELOVICH CLANCY SHULMAN
SPONSOR: Time, Cable News Network
SOURCE: TIME/C.N.N./YANKELOVICH CLANCY SHULMAN, 1990

Table 53. (Do you favor or oppose the following?) . . . The right of next of kin to stop treatment of a terminally ill patient.

Favor	63%
Oppose	26
Don't know/No answer	11

BY: RESEARCH AND FORECASTS
SPONSOR: The Hearst Corporation
SOURCE: KNOWLEDGE OF HEALTH AND PHYSICAL WELL-BEING, 1985

Table 54. Do you agree or disagree. . . there is a sacred duty to preserve life as long as possible whatever the patient or the patient's family may wish. . . ?

Agree	55%
Disagree	42
Not sure	3

BY: LOUIS HARRIS AND ASSOCIATES
SPONSOR: The Loran Commission
SOURCE: MAKING DIFFICULT HEALTH CARE DECISIONS, 1987

Table 55. Where a patient is very ill and his doctor says he has no hope of recovery, do you think that patient's family should have the right to demand that he be kept alive by a very expensive life-support system?

Yes, should have	33%
No, should not have	63
Not sure	4

BY: LOUIS HARRIS AND ASSOCIATES
SPONSOR: The Loran Commission
SOURCE: MAKING DIFFICULT HEALTH CARE DECISIONS, 1987

Table 56. Do you think doctors should be allowed to withdraw life-sustaining treatment for a terminally ill patient who is . . . unconscious but whose family requests it?

Yes	70%
No	21
Not sure	9

BY: YANKELOVICH CLANCY SHULMAN
SPONSOR: Time, Cable News Network
SOURCE: TIME/C.N.N./YANKELOVICH CLANCY SHULMAN, 1990

IV
TOWARD EUTHANASIA

Table 57. When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?

	1991	1990	1989	1988	1986	1985	1983	1982	1978	1977	1973	1947
Yes	70	69	66	66	66	64	63	61	58	60	53	37
No	25	26	30	29	31	33	33	34	38	36	40	54
Don't know	5	5	4	5	4	3	4	5	4	4	7	9

BY: NATIONAL OPINION RESEARCH CENTER (1977-91); GALLUP ORGANIZATION (1947-73)
SOURCE: GENERAL SOCIAL SURVEY (1977-91); GALLUP POLL (1947-73)

Table 58. Do you think that the law should allow doctors to comply with the wishes of a dying patient in severe distress who asks to have his life ended?

Should allow	53%
Should not allow	38
Not sure	8
No answer/Refused	2

BY: LOUIS HARRIS AND ASSOCIATES
SPONSOR: The President's Commission for The Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.
SOURCE: MAKING HEALTH CARE DECISIONS, 1982

Table 59. Do you think the patient who is terminally ill, with no cure in sight, ought to have the right to tell his doctor to put him out of his misery, or do you think this is wrong?

Ought to be allowed	49%
Think this is wrong	38
Not sure	13

BY: LOUIS HARRIS AND ASSOCIATES
SOURCE: HARRIS SURVEY, 1977

Table 60. If someone has a disease that cannot be cured, do you think there should be a law allowing doctors to end the patient's life by some painless way if the patient and his family request it, or don't you think so?

Yes, should be a law	63%
No, should not be a law	30
Not sure	7

BY: NBC NEWS/WALL STREET JOURNAL
SOURCE: NBC NEWS/WALL STREET JOURNAL, 1988

Table 61. Do you think a person has the right to end his or her own life if this person . . . has an incurable disease?

	1991	1990	1989	1988	1986	1985	1982	1978	1977
Yes	57%	56%	47%	50%	52%	44%	45%	38%	38
No	40	38	49	46	45	53	50	58	59
Don't know	3	6	5	4	3	3	5	3	3

BY: NATIONAL OPINION RESEARCH CENTER
SOURCE: GENERAL SOCIAL SURVEY 1991, 1990, 1989, 1988, 1986, 1985, 1982, 1978, 1977

Table 62. Do you think a person has the moral right to end his or her life under these circumstances . . . when this person has a disease that is incurable?

Yes	58%
No	36
Refused/No opinion	6

BY: GALLUP ORGANIZATION
SOURCE: GALLUP POLL, 1990

Table 63. Do you think a person has the moral right to end his or her life under these circumstances . . . when this person is suffering great pain and has no hope of improvement?

Yes	66%
No	29
Refused/No opinion	6

BY: GALLUP ORGANIZATION
SOURCE: GALLUP POLL, 1990

Table 64. There is a ballot question in the November election in Washington state which would make it legal for doctors to assist a patient who wishes to die if at least two physicians have diagnosed the patient as terminally ill, with six months or less to live. Doctors would be legally permitted to give a lethal injection or provide a patient with a lethal dose of drugs. In addition, state law would specify that individuals can request in advance that food and water be withheld in the event they are hopelessly ill or injured. If this question were to appear on the ballot in your home state, would you vote for or against the question?

For	61%
Against	28
Don't know	10
Refused	1

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 65. Do you think that the law should allow doctors to comply with the wishes of a dying patient in severe distress who asks to have his life ended?

Yes, should allow	62%
No, should not allow	34
Not sure	4

BY: LOUIS HARRIS AND ASSOCIATES
SPONSOR: The Loran Commission
SOURCE: MAKING DIFFICULT HEALTH CARE DECISIONS, 1987

V

LIVING WILLS

Table 66. Do you personally have a written living will that states what should be done in case you have a terminal illness or injury, with no hope of recovery?

Yes	17%
No	83
No Opinion/Don't Know	0

BY: ABC NEWS/WASHINGTON POST
SOURCE: ABC NEWS/WASHINGTON POST, 1991

Table 67. Do you have a living will?

Yes	24%
No	76

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 68. Do you, yourself, have a written "living will" which states what should be done in case you have a terminal or debilitating illness or injury, with no hope of recovering?

Yes	20%
No	80
Don't know/Refused	0

BY: GALLUP ORGANIZATION
SOURCE: GALLUP POLL, 1990

Table 69. Do you happen to have a living will for yourself?

Yes	16%
No	83
Refused	1

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #, 1990

Table 70. Have you filled out what is known as a "living will" stating those wishes (concerning the use of life-sustaining treatment if you ever enter a coma from which doctors do not believe you can recover)?

Yes	15%
No	84
Unsure	1

BY: TARRANCE/S.R.I.
SPONSOR: American Medical Association
SOURCE: HEALTH CARE ISSUES, 1988

Table 71. Have you ever heard of a "living will? "

Yes	71%
No	28
Don't know	1

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1, 1990

Table 72. Are you at all familiar with the concept of a living will, in which a person leaves written instructions detailing his or her wishes on the use of life-sustaining treatment if he or she were terminally ill and in a coma or otherwise unconscious?

Yes	80%
No	19
Don't know	1

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 73. Starting on December first (1991), the federal government will require all hospitals to tell patients they have the right to make a living will or to designate someone to make medical decisions for them if they cannot. Do you approve or disapprove of this new law?

Approve	84%
Disapprove	6
Don't know	9
Refused	1

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 74. Do you think the (federal) law (which requires all hospitals to tell patients they have the right to make a living will or designate someone to make medical decisions for them if they cannot) should allow doctors to honor the written instructions of their patients even if it means allowing them to die?

Yes	81%
No	8
Don't know	11

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 75. Have you told your family or closest friend what your wishes would be concerning life-sustaining treatment if you ever enter a coma from which doctors believe you will never recover, or have you not?

Yes	67%
No	32
Don't know	1

BY: KRC COMMUNICATIONS/RESEARCH
SPONSOR: Kaiser Foundation
SOURCE: NATIONAL ATTITUDES TOWARD DEATH AND TERMINAL ILLNESS, 1991

Table 76. Have you told your family what your wishes would be concerning the use of life-sustaining treatment, if you ever enter a coma from which doctors do not believe you can recover?

Yes	56%
No	43
Unsure	1

BY: TARRANCE/S.R.I.
SPONSOR: American Medical Association
SOURCE: HEALTH CARE ISSUES, 1988

Table 77. With whom, if anyone, have you discussed your wishes for (stopping or continuing) your own medical treatment in these kinds of (certain) circumstances? (Do not read)

Husband/wife	34%
Child	15
Parent	15
Other relative	13
Doctor or nurse	4
Friend	9
Other	3
No one	36

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1 , 1990

Table 78. Are your own wishes for (stopping or continuing) medical treatment (in certain circumstances) written down somewhere?

Yes	13%
No	87

BY: PRINCETON SURVEY RESEARCH ASSOCIATES
SPONSOR: Times Mirror
SOURCE: REFLECTIONS OF THE TIMES #1, 1990

VI

SELECTED STUDIES

Table 79. Assume that you developed a terminal illness which has progressed and caused your heart to stop beating. Given these circumstances, you would want CPR. [Asked of physicians.]

Strongly Agree, Agree, or No Strong Feelings	14%
Strongly Disagree or Disagree	86

SOURCE: BRUNETTI, CARPEROS & WESTLUND STUDY, 1989

Table 80. Assume that you are mentally incompetent suffering from a terminal illness which has caused your heart to stop beating. Given these circumstances, you would want CPR. [Asked of physicians.]

Strongly Agree, Agree, or No Strong Feelings	7%
Strongly Disagree or Disagree	93

SOURCE: BRUNETTI, CARPEROS & WESTLUND STUDY, 1989

Table 81. If you became permanently unconscious in a persistent vegetative state and could not eat normally, you would want your life maintained through artificial feedings. [Asked of physicians.]

Strongly Agree, Agree, or No Strong Feelings	8%
Strongly Disagree or Disagree	92

SOURCE: BRUNETTI, CARPEROS & WESTLUND STUDY, 1989

Table 82. If you were about to die of natural causes, would you want us to keep you alive by drugs, fluids, food by tubes, breathing machines, and heart massage? [Asked of nursing home residents.]

Yes	26%
No	68
Delay	5

SOURCE: DIAMOND, JERNIGAN, MOSELEY, MESSINA, & MCKEOWN STUDY, 1989

Table 83. [Preference for following treatments if terminally ill.]

	Yes	Undecided or Qualified	No
Want CPR	0%	22.2%	77.8%
Want respirator	0	7.9	92.1
Want nasogastric tube feeding	1.6	9.5	88.9
Want intravenous fluids	6.3	19.1	74.6
Want oxygen for comfort	65.1	14.3	20.6
Want antibiotic therapy	23.8	34.9	41.3

SOURCE: HENDERSON STUDY, 1990